Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1, perMD, g877, 3/3/08 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JAN. 18, 2008 **Physician** Willis Gibson 6:03A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ouden 20 Yenue more If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min Months Days Hours 77 247-48-9927 S. CAROLINA 12/09/1930 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County BALTIMORE CITY MD N/A 1 X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 420 N. LOUDON AVENUE 21229 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No BLACK Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 4TH College (1-4or 5+) CONSTRUCTION WORKER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELLIOTT GIBSON MAGGIE YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 420 N. LOUDON AVENUE, BALTIMORE, MD 21229 AZALEE GIBSON / WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ARBUTUS MEM. PARK 01/26/08 BALTIMORE CO., MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD mot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death complications that caused the death. Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consultance of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and -tran physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 24

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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Division or Vital Records, P.O. Box 68760, C	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1_	For State Registrar	11000	State of	of Marylan	d / Dep		Health a	and Mer	ntal Hygi	•	^ ^	A 1 2	70 0
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State Registrar	30		ness of person w	po completed caus 32. F	se of death (Item	305	1	13/ tal D	rue, (The s	January Bushit	1 f	1. 40	26/

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nelda Giordano 11:50 A M 22 Jan. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7 Elphin Ct. Unit 102 Timonium Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vis. last birthday **Funeral** Months Days 1 🗆 M 94 10 1913 Italy Director 166-28-6233 Dec. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County show r 28a-f she notified a 1 ☐ Yes 2 No MD Timonium Baltimore Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number or be Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 7 Elphin Ct. Unit 102 ral", or Items 23a Examiner must b 21093 USA by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ∏Yes 2X No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify Specify: white 3√ Widowed 4 Divorced Year or Dates: 'natural", er than "natur , the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Own Home n/a Homemaker 27 is marked other traumatic event, to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pasquale Pallini Judita Zani ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ann Giordano R.S.M./daughter7 Elphin Ct. Unit 102, Timonium, MD 21093 item 27 i other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of Grace Cem. 1/26/08 Langhorne, PA 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Signature of Fun and Service Libers of Inc. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2. Congestive Weeks Physician /Medical Due to (or as a convequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the burial by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent preg 3 □Ectopic pregnancy Month in the past 12 mg Year 5 Other (specify) ⊒Yes 2. No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of this certificate 1 Ti Yes 2□ No 1 Tyes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only open Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of after death. I Director: After the in by the funeral 27. Manne eath 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 L Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral C

Registrar

State

Medical

29a. Certifier

(Check only one)_

29b. Signature and title of certifier

Daniel Levy, M.D. 31. Date filed (Month, Day, Year)

JAN 2 4

30. Name an Varidress of person who completed cause of death (Item 23a) (Type, Print)

GBMC 6701 N. Charles St., Suite 5105, Towson, MD

DHMH 17 Rev 1/2001

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

23, 200 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:00 AM Physician 2008 Garner 25 V. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anno Arunder Anne Aninck Medical Center Annapoli If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 87 Yrs. Social Security Number 6. Sex Funeral Months Days Hours 12M 2□ F 219-03-9054 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ann of Health and Mental Hygiene.

ann of Health and Mental Hygiene.

any or other traumatic event, the Medical Examiner must be any or other traumatic event, the Medical Examiner must be any United States 21060 101 Inglewood Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 M Yes 2 □ No WW I I If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White timore, Maryland 21215-0036 Specify Completed by 3 \ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Natural Resourts Game Warden 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Loible Holli C. Garner Rachel ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Garner- Hudak (Daught¢r) 101 Inglewood Drive, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 29, 2008 20c. Location - City or Town, State 20a. Method of Disposition Department of F Important: If ite any injury or of ↑ Burial 2 Cremation 3 Removal from State Cheltenham, Maryland Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Fureral Service License Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 50 disease or condition resulting in death) /Medical Due to (or sa a o nse wence d Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Ital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 1 ☐ Live birth Month 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part, II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 No in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Inpatient မှ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the hospital or Attending P within 24 hours after death.

To the Funeral Director: After Medical Certification: Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) X

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mo

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 3:03 am Aubrev Gwenville Goshen JANUATU 7.2008 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Medical 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 83 579-22-0443 12/4/1924 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Directo Maryland | Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 2003 Wendy Ct. Funeral U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status "natural", or Item adical Examiner r Black, White, etc. 1 Yes 2 N If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 ☐ No 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced 1941 Completed 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 General Services Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ို Unknown Helen Amelia Rhodes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury it oner trau 5103 43rd Ave. Apt.4 Hyattsville, MD 20781 Brád Goshen (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/22/2008 | Clinton, MD Resurrection 21. Signatur Ft, eral S, vice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 01d Alexandria Ferry Rd. Clinton, MD 20735 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Clostridium difficle colitis Examiner hours Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ osteoarthritis , hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed thorax back decubuti ulcer (MRSA 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Yes 2√2 No 1 Nopatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the letely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R. Singlewal January 17th, 2008 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sp. WALdorf 20603 4 2008 Registrar

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es 1 and 2 of Health of Fitem 27 is	other	20a. Method of Disposition			Disposition (Name , crematory or other	of	Date 2	Oc. Location - City or				
Pages nent of lint; If ite	ry or	Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		/		JAN. EST VETER	30,2008 AN CEM	OWINGS	MILLS,MD.			
permit. Page Department of Important: If	any Inju	21 Signature of Funeral Service Lice	rsee		22. Name and A	Address of Facility		NERAL HON	·			
4 00 5	@ OI	23a. Part1. Enter the disease, or com	nlications that caused	the deliv Don	1412	F DDFCT	ON ST F	BALTO, MD	21213 Approximate			
Physic	ian	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each li	RIAL CAN			, , , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death			
/Med Exami	_	resulting in death)		a consequence o								
l e	it liner	Sequentially list conditions, if any, leading to immediate cause. Littlet Underlying Cause (Disease or injury	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
executed in and	ial-transit Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of	f):							
	e burial		-d.	a concequence o	.,.							
rtificati	as the bu	IF FEMALE:										
the death c_rtificate be y the attending physicia	et ched for use a	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal death	3 □Ectopic preg 5 □ Other (spec			23d. Date of de Month	livery Day Year			
	0 _	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying caus	se given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?			
equires en sign							1 ☐ Ye	s 2 □ No 3 □ P	robably 4X Unknown			
The la	OL O						24a. Was an autopsy perform 1∐ Yes 2	prior to				
	Be (25. Was case referred to medical examiner?	Hospital:			Other	ath (Check only one	,				
lcia cert		1 ☐ Yes 2 No	28a. Date of Inju	ıry 28b. T	ime of 28c	4 ☐ Nursing H Injury at Work?	forme 5 ☐ Resider 28d. Describe how	nce 6 XIOther (Spe w injury occurred	ecity) HOSPICE			
Physician r this cert		27. Manner of Death		y Year) In	ijury M	Work? 1 ☐ Yes 2 ☐ No						
ing Phy:	uneral di on: To	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	i								
ing Phy:	uneral di on: To	1 Natural 5 ☐ Pending	e 28e. Place of inj	ury - At home, far c. (Specify)	m, street, factory, o	office	28f. Location (Str. City or Town,	eet and Number or R State)	lural Route Number,			
ing Phy:	uneral di on: To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Pending investigatio 6 Could not be determined	e 28e. Place of inj building, et	of my knowledge		office the time, date and place n my opinion, death occ	City or Town,	State)				
spital or Attending Physors after death.	uneral di on: To	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of inj building, et	of my knowledge	, death occurred at d/or investigation, in		City or Town, e, and due to the ca urred at the time, da	State)	is stated. le to the cause(s)			

State Registrar DR. TARIO MAHMOOD
31. Date filed (Month, Day, Year)

JAN 2 4 2008

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3725

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ļ		epartment of Health and Me Certificate of Death	entai Hygie Reg.	- ZIHIK H 15 H L
	Physici		1. Decedent's Name (First, Middle, Last) LILLIAN	GOLDMAN	2. Date of Death Month JANUARY	Day 21 2008 7:00A M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 3211 CLARKS LANE, APT. #216	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
- A	Funeral Director		5. Social Security Number $359-14-5898$ 6. Sex $1 \square$ M $2 \square X$ F 7. Age (In yrs. last birth 91		8. Date of Birth Month, Day, Ye 09/15/19	·
	aryland show d at	L.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town			10d. Inside City Limits
	with the Marylan a or 28a-f show be notified at	Director	MD N/A BALTI 10e. Street and Number	MORE 10f. Zip Code	10g.	1 XYes 2 No Citizen of What Country?
	eath witl is 23a o must be		3211 CLARKS LANE, APT. #216	21215	oify Ves or No-	USA 14. Race - American Indian,
900	be filed within 72 hours after death with the Maryland Hygiene. 4 other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE
21215-0036	hin 72 h e. an "natu Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of workin life. DO NOT use retired)	9 16t	b. Kind of Business/Industry
d 21	filed wit Hygien ther th		12 17. Father's Name (First, Middle, Last)	NURSES AIDE 18. Mother's Name	(First, Middle, Mai	MEDICINE den Surname)
Maryland		To Be		SHER ROSE		MORRIS
	nd 2 s ulth ar 27 is r trau		BRUCE GOLDMAN / SON 66	Mailing Address (Street and Number or Rural 503 PIMLICO ROAD, BAL		
more				Disposition (Name of crematory or other place) MEMORIAL PARK 01/22		c. Location - City or Town, State PALATINE, ILLINOIS
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee			ON & BROS., INC. IKESVILLE, MD 21208
	tificate be executed Medical Examiner as the burial-transit	ledical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a	herest	respiratory arrest,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?
		Completed			24a. Was an autopsy performed 1 Yes 2 X	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\)
3	iysic) is ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26. Place of Death patient 3 DOA Other: 4 Nursing Hom		e 6 ⊟Other (Specify)
Division or	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or	Certification:	27. Manner of Death 1	me of 28c. Injury at 2 2 Work? M 1 Yes 2 No	8d. Describe how i	injury occurred et and Number or Rural Route Number,
;	ne Hospit n 24 hours ne Funera netely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, a /or investigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	To th within To th comp.	Me	29b. Signature and title of certifier , MD	29c. License number		Date signed (Month, Day, Year)
	le		30. Name and address of person who completed cause of death (Item 23a) (Toman Transaction (Tanksaction))			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 4 2008 32 Registrar's Signature	fresh		

		PI	ease T							All Copies		.egible.		
		For 1 _ State		State of N	Marylan					Mental Hy	giene			
	-	Registrar 1. Decedent's Name (First, M.	iddle Last)			Ce	rtificate	OIL	<i>Jeath</i>	2. Date of De	Reg. No.	2000	3. Time of Do	08
Physici		ELMER	4410, 2401,	ŀ	4		GOLI	DNER		Month Januare	Day	Year 2008		
/Medic Examin		4a. Facility Name (If not instit		treet and number	er)	-			Location of Deat		-	County of Dea		
	45	surai Hospit			nore		Bal		_				N/A	
Funeral		5. Social Security Number	6. Sex	7. M 2□F		last birthday Yrs.		Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 05/22	th y, Year)	9. Bir	thplace (State or Fountry)	oreign
Director		218-12-4992 Usual Residence of Deceden			83					05/22	/1924	-	MD	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	_	10a. State 10b. Cou	Inty LTIMOI	DE		y, Town or L		-					10d. Inside City	
72 hours after death with the Marylar 72 hours after death with the Marylar "natural" or items 23a or 28a-f show adical Examiner must be notified at	Director		_ 111101	NL	D	ALITM							1 □ Yes 2	No No
with t		10e. Street and Number	COLLA	DE DDIVE			10f. Zip (00		10g. Citiz	en of What Co	ountry?	
death ms 23 must	Funeral	9201 HOWARD		2. Was Decede	nt Ever in U.	.S. 13.	Was Decede	2120 ent of His		pecify Yes or No to Rican, etc.)	j- 1	USA 4. Race - Ame	encan Indian,	
after or ite		1 □ Never Married 2 📉 I		Armed Force 1 X Yes 2[If Yes, Give	s?] No		If Yes, specif		n, Mexican, Puerl Specify:	to Rican, etc.)		Black, Whit	•	
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be filed within 72 ho tal Hygiene. d other than "natul event, the Medical	Completed	Elementary/65condary (0-1	2)	College (1-4d	or 5+)			VAGÉ				EDMAR	T DELI	
e filed al Hyg othe	Be C	17. Father's Name (First, Mid	dle, Last)						18. Mother's Nar	ne (First, Middle	, Maiden S	Surname)		
2 should be filed withing and Mental Hygiene. is marked other than aumatic event, the M	To E	BENJAMIN				GOLDI			DORA				FRANK	
d 2 should the and Mer 7 is marke traumatic		19a. Informant's Name/Relat		′						ural Route Numb				
1 an Healt Healt Sther		ROSE GOLDNE 20a. Method of Disposition	X / W.	IFE	20b. F	Place of Disp	osition (Name	o of	· · · · · ·	RIVE, BA	_	JKE, ML ation - City or		
permit. Pages Department of Important: If its any injury or of		1 XBurial 2 □Cremati 4 □Donation 5 □ Othe		emoval from Sta	te C	emetery from	NO CON	Terplace UC	1ZUK	/2008		TIMORE	·	
mit. I partm portar		21. Signature of Funeral Sen		e	1		2. Name and						S., INC.	
		Koluto	/	-		•	8900	REI	STERSTO	N ROAD	- PIk	KESVILL	E, MD 21	208
		23a. Part1. Enter the disease shock, or heart failure.	, or complic List only on	cations that caus e cause on each	ed the deat line.	h. Do not en	ter the mode	of dying	, such as cardia	or respiratory a	rrest,		Approximate Interval Betwe	en
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		noncu		spolis	4~~					5 days	101
Examiner					as a conseq		ancer	ed 1					,	
M L Myst.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		as a conseq		wie.	7	my.				6 mon	the
executed n and ial-transit	Examiner	that initiated events	100						107-1			N.		70
be executed sician and burial-transit		resulting in death) Last		Due to (or a	as a conseq	uence of):								
The law requires that the death certificate be the has been signed by the attending physician age 2 should be detached for use as the bur	Physiclan/Medical		d											
n certii Inding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	2:	3c. If yes, outcor							2:	3d. Date of de	livery	
death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		1□Live birth 4□Pregnant 9□Unknowr	at time of d		□Ectopic pre □ Other (spe					Month	Day Yea	аг
that the de	Phy	9 Unknown	dial			W				the street				
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w requires been signer should be	etec		1-1											
The larate has	Completed	-									psy prmed?	prior to death?	utopsy findings ava completion of caus	se of
10 T	ø	25. Was case referred to med	lical						26. Place of Dea	1 Yes ath (Check only o	2XNo	1 ∐ Yes	s 2□No	
Attending Physician: r death. ector: After this certific by the funeral director,	To B	examiner? 1 ☐ Yes 27 No	Н	ospital: Impa	ıtient 2□	ER/Outpatie	nt 3□ DOA	Othor	p-	lome 5□Resi		□Other (Spe	ecify)	
Ilng P	iio	27. Manner of Death 1 Natural 5 □ Pe		28a. Date of I	njury Day Year)	28b. Time o Injury		c. Injury Work?		28d. Describe	how injury	occurred		
i or Attendi after death. Director: A in by the fu	ertification:	3 Suicide 6 □ Co	estigation uld not be	28e. Place of	iniury - At ho	ome farm st	M reet factory		es 2 □ No	28f Location (Street and	Numberer	ural Route Numbe	
al or / s after il Dire	ertii	4 ☐ Homicide del	ermined	building,	etc. (Specif	y)	, , , ,			City or To	vn, State)	rearriber of 11	arai rioate marripe	"
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	cal C	29a. Certifier 1 Cert	fying Phys	ician: To the be	st of my kno	wledge, dea	th occurred a	t the time	e, date and place	and due to the	cause(s)	and manner a	s stated. e to the cause(s)	
the H hin 24 the F mplete	Medical	one)		and manner	stated.					ined at the time,				
To wit		29b. Signature and title of cer						License	- 000				th, Day, Year)	
.07		30. Name and address of per	M.D		f dooth (Ita-	03e\ /7					Jan	ierry.	19 200	5
18		30. Name and address of per Raghawan Deepa 31. Date filed (Month, Day, M	, MD, S	nai Has	pital	of Bal	timore	,241	OI W'Bel	wedere i	Avenu	e, Balli	more 40	21215
Sta	te	31. Date filed (Month, Day, Y	ar)	32. egi:	strar's Signa	ature	Cast)	-						
Registr	ar	JAN 3	; 4 ZU	UX D	ر مص	A A	000 OL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18, **Physician** Raymond A. Hall January 2008 11:10 PM /Medical 4a. Facility Name (If not institution, give street and number)
113 Melvin Avenue Examiner 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Mar. 22, 1 5. Social Security Number 213-10-7354 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 96 Months Days Hours Director 1911 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Director Baltimore 1 ☐ Yes 2X No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Melvin Avenue Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 ☐ Divorced White 'naturai", the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Transportation Truck Driver John Wesley Hall Be 18. Mother's Name (First, Middle, Maiden Surname) Larmie Ellen Comer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Melvin Avenue, Catonsville, MD 21228 Ray Allan Hall - Son 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Meadowridge
Memorial Park Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 D0th Sign the of Funeral Se 5 ☐ Other (Specify) 1-25-2008 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home, 2719 Hammonds Fry Rd., lansdowne, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure /Medical Due to (or as a consequence of) Examiner COPD, End Stage Sequentially list conditions if any afficient limit of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Jas autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 21 No Other: 4 \(\sum \) Nursing Home dir 10 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation in 24 hours after control the Funeral Director: After the funeral filled in by the funeral fun 2 Accident 1 Tyes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier To th. within 2. (Check only one)

Registrar

29b. Signature and title of certifier

B

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6095

Registrar's Signa

29c. License number

D L 2523

29d. Date signed (Month, Day, Year)

January 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hollingsworth 11:35 AM rrances 22 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year)
Mar 30,1932 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. age (In vrs. last birthday 5. Social Security Number **Funeral** Days 1□M 2\ F Hours 75 218-28-8385 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d Inside City Limits 10b. County 1 ☐ Yes 2 💆 No **Funeral Directo** Laurel Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20707 USA 7901 Laurel Lakes Court, Apt#126 12. Was Decedent Ever in U.S Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2☐No Specify 9 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be John R. Redmiles Amanda Foster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Herberson, Daughter 9076 Old Scaggsvil<u>le Road Laurel, MD 20723</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc.: 01/23/08 Baltimore, Maryland 21. Signature of Funeral Service Unensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to for as a consequence of):

Metal Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Securitielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician as the t been signed by the should be detached has this certificate or Attending Physician: After ours after death.

Peral Director: A
filled in by the fu within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number D-64372

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sana Misalati MD 5755 Cedar Lane Columbia, MD 21044

31. Date filed (Month, Day, Year)

2008

 ,	9.0						
	Reg.	No.	2	0	0	8	(

1914

USA

2.

Reg	g. No.	2008		5	
Date of Death			3. Time	of Deatl	1
Month nuary	16,	2008	8:	00 P	N

Prince George's

14. Race - American Indian

Black

20011

Approximate Interval Between Onset and Death

Black, White, etc.

Virginia

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

4c. County of Death

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

Private Families

20774

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

20017

Year

Month

2⊠ No

Brentwood, MD

Physician /Medical **Examiner**

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 28a-f show items 23a or 28a-f shiner must be notified ō "natural" er than "natur , the Medical n and Menta

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

The law requires that the death certificate be executed physician and burial-transit the attending the been signed by the should be detach page 2 After this certificate or Attending Physician; funeral reral Director: A

Division or Vital Records, P.O. Box 68760,

Ja 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) St. Thomas More Nursing & Rehab Hyattsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 🕱 F Yrs. 224-14-5590 93 Dec. 18, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County MD Prince George's Hyattsville, MD Directo 10f. Zip Code 10e. Street and Number 20782 4922 LaSalle Road Funeral 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ottie Mickle George Washington Wash Fore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Springdale, MD Ruth D. Legette/Legal Guardian 3626 Cousins Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 01-25-2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final Hypertensive Cardiovascular Disease disease or condition resulting in death) Due to (or as a consequence of): Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Progressive Cognitive Decline 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident

29b. Signature and title of certifier

Juanitez,

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD21525

1160 Varnum Street, NE Ste 008 Washington, DC

January 18, 2008

31. Date filed (Month, Day, Year) JAN 2 4 20 State Registrar

3 ☐ Suicide

4 Homicide

(Check only

30. Name and address of person who c

Esmerando 0. 32. Registrar's Signature 2008

MD

Ø

within 24 hours a

To the Funeral I

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

eted cause of death (Item 23a) (Type, Print)

State

HOFN

Registrar

31. Date filed (Month, Day, Year)

JAN 24

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAHID SAEED ND 6830 HOSPITAL DR, BACTIHERE, HD

32 registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month HOHLBEIN January 2008 II:20A ™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMORE BALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1∰M 2□F Country) Maryland Months Hours 77 212 28 0463 Director 16, Feb. 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- "any injury or other traumatic even." 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Marvland Baltimore Baltimore 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Yarnall Road 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ⅓Yes 2 □ No If Yes, Give Korean Year or Dates: Korean 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify δ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Box Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Albert Hohlbein Ruth M. Mans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Hohlbein / Daughter 241 - 12th Street Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 01/21/2008 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the dispasi, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** temorrh agic /Medical Examiner nomboca Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death ate of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 5 ☐Pending investigation (Month, Day Year) 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

State Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL, 3001

SVATU SINGLA LONG, MD - BALTIMORE MP 2

31. Date filed (Month Day, Van)

32. Register's Signature

January 16,2008

Physician /Medical Examiner **Funeral** Director 28a-f show other traumatic event, the Medical Examiner must be notified Director ō or items 23a Funeral 5-0036 þ 'natural", Completed than and Mental Hygie Is marked other Maryland Be pe ျှ Department of Health a Important: If item 27 Is any Injury or other tra Baltimore, Pages 1 permit.

HARRISON

ALEXANDER

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9 byAnder 2008 Anuam 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death 4730 ATRIUM COURT, #474 BALTIMORE OWINGS MILLS 8. Date of Birth (Month, Day, Year) 01/18/1920 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Months Days Hours Min. 217-05-1248 88 Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 ATRIUM COURT, #474 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Armed Forces?

1 1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 💥 No WHITE Specify Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) INVESTIGATOR ADMINISTRATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAHAM HARRISON SARAH UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS ROSEN / NIECE 24 CLARKS LANE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3 DRemoval from State 15 ☐ Other (Specify) HEBREW YOUNG MENS 01/21/2008 BALTIMORE, MD 4 □ Donation SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). endicus cular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) the 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an , page 2 has autopsy performed certificate Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 1 Tes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 Natural 5 ☐ Pending I hours after death.

uneral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours at To the Funeral D 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who strar's Signature 31. Date filed (Monti State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per fth 9875 1-24-08 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 20, 2008 JAN. 4:25A THOMAS P. JACKSON /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE CITY MANORCARE - ROLAND PARK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex Hours **Funeral** Days Months 1**X** M 2□ F 11/24/1947 212-46-6409 60 MARYLAND Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐Yes 2 No PIKESVILLE MD BALTIMORE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 1300 ROBIN ROAD by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BETHLEHEM STEEL than Elementary/Secondary (0-12) College (1-4or 5+) CORPORATION STEEL WORKER 12TH permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygir Important: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN MIDDLETON LEROY JACKSON 2 other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1300 ROBIN ROAD, PIKESVILLE, MD 21208 THOMAS JACKSON / SON 20b. Place of Disposition (Name of DUCANEY CRAFT STHER Place) 20c. Location - City or Town, State 20a. Method of Disposition **X**Burial 2 □Cremation 3 □Removal from State 5 01/24/08 TIMONIUM, MD MEMORIAL GARDENS injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of paperal Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 any 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD or complications that caused the death List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, eart failu ate Cluse (Final **Physician** ondition in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Day to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician as the IF FEMALE: use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Dav Year for in the past 12 months? 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s certificate 2⊟No 1□ Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of _eath Check onl_one Be 25. Was case referred to medical examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury Hospital or Attending (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3□ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31464 SZIN, ENTAN ST Ant 300 BALTIMORE MI) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40819W1 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 4

2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:54 p M Mary Celeste Jones January 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Caroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days 1 □ M 2X F JUN 10 1928 Hours 79 Maryland 214-22-7687 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at angle. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore Howard Rockdale 1 □Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 21244 21044 10g. Citizen of What Country? 8320 Lages Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Rental Agent Property Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Thomas Ρ. Elliott Marie Lochboehler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Rainey - Daughter 1622 Bowersox Road, New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 1/21/2008 Baltimore, MD ^{22, Name and Address of Facility} Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner 1050 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician at the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wonknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 은 1 ☐ Yes 2 ☐ Xo 1 | Inpatient 2 ER/Outpatient 3 DOA hours after death. uneral Director; After this ly filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours are
To the Funeral Div 29a. Certifier 1 C-critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kise MI) VII 00064597-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) to, mD 21157

State

Registrar

Centh St

2. Registrar's Signature

5

31. Date filed (Month, Day, Year)

JAN 2 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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E.un	~	3	W.	V.	2	V	- 5	4

	I- For State	of Maryland / Depa Cer	rtment of tificate of		l Mental Hy		20	08 0151					
	Registrar 1. Decedent's Name (First, Middle,Last Tim	othy Just	in K	nox		2. Date of Death	n Dav Year	3. Time of Death 0315 hrs					
adain .	4a. Facility Name (if not institution, give Prince George's Hospital	e street and number)	4t	Cheverly	ocation of Death		4c. County of De Prince Geo						
Funeral Director	5. Social Security Number 6. Se	7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or reign Florida Country)					
	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	n				10d. Inside City Limits					
land f show once.	Md Charles	Whi	te P1	ains				1 Yes 2 XNo					
ith the Maryland 23a or 28a-f show any notified at once, al Director	10e. Street and Number 7905 Heatherle	eigh Place		10f. Zip Code 206	595		g, Citizen of What (USA	Country?					
fler death with ", or items 22 er must be no / Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year	If Ye		panic Origin? (Spe Mexican, Puerto F specify:		14. Race - Al White, et						
hours aft	15. Decedent's Education (Specify or	ly highest grade completed)	16a. Decedent'	s Usual Occupation	on (Give kind of we		16b. Kind of Busine						
5-0036 lled within 72 llygiene. I other than "" the Medical E Complet	Elementary/Secondary (0-12)	College (1-4 or 5+)	Serve				Restau	rant					
21215-0 und be filed w Mental Hygi marked othe cevent, the I To Be Co	17. Father's Name (First, Middle, Last) Dary1	Knox		1	8.Mother's Name (^{laiden Surname)} Hawkins						
MD 21 d 2 should th and Me: n 27 is man numatic ev	19a. Informant's Name/Relationship (T Vivian Hawkir		19b. Mailing 7905	Address (Street Heathe	and Number or Ri erleigh	ural Route Num	ber, City or Town, S ite Pla	ins,Md 20695					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Po	Place of Disposit	ion (Name of cem	netery.	Date	20c. Location - Cit	y or Town, State n, Georgia					
	21. Signature of Funeral Service Licen	see / M CC	22. No Ch 26	me and Address inn Fur 05 S.S.	of Facility neral S hirling	ervice ton Rd	.Ar1.Va	.22206					
Physician /Medical aminer	Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Due to (or as a consequence of):												
	Sequentially list conditions, b.												
in i	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of Due to (or as a consequence of											
	events resulting in death) Last d.	Due to (or as a consequence of	<i>j</i> .										
60, tte be execu nysician and burial - tra	UNPENDED	AMENDED 23c. If yes, outcome of pregr	nancy				23d. Date of del	Nep.					
ox 687 The certific true as the recent from t	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of dea	2 Feta	al death 3 er (Specify)	Ectopic pregnar	ncy	Month	Day Year					
P.O. Be as that the degline to be detached for by Phys	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	iderlying cause gi	iven in Part I.			e to the cause of death? Probably 4 Unknown					
n of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach on: To Be Completed by P.						24a. Was a	an 24b. Wer	e autopsy findings available to completion of cause of					
Rec i: The la iificate h or, page 2	25. Was case referred to medical			26 Place	of Death (Check o	1 Yes 2		Yes 2 No					
Vital hysician hysician this cert of directo	aveminar?	lospital: 1 Inpatient 2	ER/Outpatient		Other:		Residence 6 0	Other:					
Division of Vital Records, tal or Attending Physician: The law requirant and after death and Director. After this certificate has been seled in by the funeral director, page 2 should tertification:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day Year) Jan 21, 2008	28b. Time of In 2235 hrs				now injury occurred auto fixed objec	t collision					
Division of To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral control of the funer	3 Suicide 6 Could not determined	28e. Place of Injury - At ho		, factory, office bu		or Town, St		r Rural Route Number, City vn , MD					
To the Hosp within 24 hos To the Fune completely fi		an: To the best of my knowledge: On the basis of examination are and manner stated.											
Me s s s s	29b. Signature and title of certifier			29c. License O.C.N			29d. Date signed January 22, 2						
5	30. Name and address of person who on Donna M. Vincenti, MD	completed cause of death (Item Assistant Medical Exam	,	Penn Street,	Baltimore, MI	D 21201							
State Registrar	31. Date filed (Month, Day, Year)	32. régistrar's Signatu	Se Soon	W									
DHMH 17 Rev 1/2001	OCME		ORIGINAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 21, P^{M} January 2008 12:15 John Seeger Kerns, Jr. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 74 1933 Director 215-30-6503 May 10, Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits a or 28a-f show be notified at 1 ☐ Yes 2 ☑ No Directo Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 620 Straffan Drive # 102 21093 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No
If Yes, Give Year or Dates: 53 ¹ -55 ¹ 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer/President Printing 7 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. Seeger Kerns ည Marie Louise Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Stephanie C. Kerns/Wife 620 Straffen Dr. #102 Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Pikesville, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonai Road Timonium, MD 21093 21. Signature of Funeral Service Licensee Michael J. Flagle Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ue f (fr as a consequence of): nstructestings 2 days disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, but in the distribution of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 No Chrone 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 ☐ Accident within 24 hours after death To the Funeral Director: . completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

ROSFWBERG

seen It front

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

			For State Registrar	State of Maryland		rtment of H				8 01	520
B			Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time o	of Death
	Physicia		Sarkiss N	4. Karahbetyan	1			Month Januar		98 4:35	P M
V.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death	-	4c. County of	Death	
			Shady Grove Adve	entist Hospital	L		cville		Montgo		
	Funeral		Social Security Number 6. So	™		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	h y, Year)	Birthplace (State Country)	or Foreign
	Director		069-86-8008	^{₩™ 2□ F} 60	Yrs.			November	11, 1947 S	yria	-
	and	1	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10d. Inside (City Limits
	f sho	ō	Maryland Montgom	orv	Nort	h Potoma	r			1 □Yes	s 2 🔀 No
	the 128a-notif	Director	10e. Street and Number		11020	10f. Zip Code			10g. Citizen of Wha	at Country?	
	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show atic event, the Medikal Examiner must be notified at		14664 Brougham Wa	av		20	0878		United S	tates	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race -	American Indian,	
٥	or ite		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	1	☐ Yes 2X No	Specify:	nicali, etc.)		White, etc.	
2	ral", c	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			ореспу.		Specify:	White	
21215-0036	72 h 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	ent's Usual Occup kind of work done	during most of work	ting	16b. Kind of Busin	iess/Industry	
2	/ithin ne. han *	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired hanic	2)		Auto Bod	v Shop	
7	iled v Hygie ther t		12 17. Father's Name (<i>First, Middle, Last</i>)		nec.	nanic	18. Mother's Nam	e (First, Middle,	Maiden Surname)	y bhop	
Maryland	9 E 2 S	Be o	Marcus Karahbetya					ie Marc			
Ž	should and Men s marke umatic	ဥ	19a. Informant's Name/Relationship (7		19b. Mailin	a Address (Street			er, City or Town, Sta	ate. Zip Code)	
<u>B</u>	id 2 s ith an 27 Is		Firouza Gabibova			,			omac, Mar		878
ā,	es 1 and 2 should b of Health and Ment item 27 Is marked r other traumatic e		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	201 7	Date	20c. Location - Cit	ty or Town, State	
altımore,			1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		iven Ceme	, ourie		Silver Sp	ring, Ma	ryland
	permit. Pag Department Important; I any injury o once,		21. Signature of Funeral Service Licen	·			· , ~ · · ,	~000	Rockville,		
ñ	Der Imp		Undette Barr	M0130	$5 \frac{100}{300}$	West Mont	gomery Aver	nue, Rock	ville, Mary	land 20850	-2805
			23a. Part1 Fi ter the disease, or companies or companies or heart failure. List only	plications that caused the death	n. Do not ente	er the mode of dyir	ng, such as cardia	or respiratory ar	rrest,	Approxima Interval B	ate etween
	Physician		Immediate Cause (Final disease or condition	Ventri	بدام	2 Fib	willat	ON		Onset and	VIC
*	/Medical		resulting in death)	a. Due to (or as a consequ	uence of):	0	1	Dis	100	1./	-1-5
	Examiner		Sequentially list conditions	b. (aron	m	y Ka	pery	NIS	eyse	10	An
T	p tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequ	uerice of):		(
V	ecute and -trans	Examiner	that initiated events resulting in death) Last	cDue to (or as e consequ	ience of):		- 8				
8760,	cate be executed oblysician and the burial-transit			200 10 (01 00 0 00110040	201100 01).						
28/	death certificate be executed e attending physician and of for use as the burfal-transit	dical		ed							
×	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna	incy _				23d. Date (of delivery	
Box	atter 1 for 1	cial	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnanc Other (specify) _	у		Month	h Day	Year
Ö	the cachec	hys	9 Unknown	9□ Unknown				_			
ري ح	The law requires that the de ate has been signed by the a bage 2 should be detached to	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use contrib	ute to the cause of	f death?
Records,	w require been sig should b	ed b			-			\rightarrow	es 2□No 3	Probably 4]Unknown
ပ္တ	aw re is bee 2 sho	Completed						24a. Was		ere autopsy finding or to completion of	s available
	The I	E						perfo	ormed? dea	ath?	caase or
Vital	rsician: The law s certificate has l lirector, page 2 s	Be C	25. Was case referred to medical				26. Place of Dea		one)		
	nysic lis ce direc	.0	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	R/Outpatien	t 3□ DOA Oth	ner: 4 🗆 Nursing H	ome 5□Resi	dence 6 □Other	(Specify)	
0	ng Ph ter th neral	n: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe	how injury occurred	I	
000	endlr eath. or: A he fu	atic	2 Accident investigation			M 1□	Yes 2 □ No				
Division or	or Att ter de irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str y)	eet, factory, office		28f. Location (S City or Tox	Street and Number wn, State)	or Rural Route Nu	ımber,
	oital ours af praid Differd in			7.0.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.				and due to the	anusa(a) and man		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illied in by the funeral director, is	Medical		nysician: To the best of my kno- miner: On the basis of examina and manner stated.							e(s)
	ithin 2	Mec	29b. Signature and title of certifier	and marrier stated.		29c. Licens	se number		29d. Date signed (Month, Day, Year,)
	F ≯ F ŏ		Matt.	()	an		3326		10046	1 21	1000
			30. Name and address of person who	completed cause of death Utem	1 23a) (Type,	Brinth	JJV	١,	474,400	7/	1000
	10		Milian	Dodle	1		0 Medical	Center	Dr., Roc	ville,	1D 20850
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture						
	Regist	ar	JAN 24	ر مستنقر 2008	B A	medi					
DH	MH 17 Rev 1/2	001		6-	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Walter 0908 AM 23 January 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rosedale Square HospiTAL Center FRANKLIN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1□M 2□F 68 216-34-3282 1-8-1940 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE ESSEX MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 U.S.A. 508 FUSELAGE AVENUE death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: ▼IETNAM 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married Married 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r filed within College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE CONTRACTOR TRUCKING 12 ortant: If Item 27 is marked other injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and LITTLE CATHERINE (SEIDENZAHL) WALTER Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and Department of Health ar Important: If Item 27 is any Injury or other trau 508 FUSELAGE AVE ESSEX, MD STEPHANIE LITTLE/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEMET. 1-26-2008 MIDDLE RIVER, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Fereral Service Licensee ROSEDALE, MD 21237 1211 CHESACO AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): CANCER **Examiner** LUN Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death the a 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 22 No page 2 certificate has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 🔲 Inpatient this 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 | ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. archall D 40008

State Registrar DR Jim W. Parshall 9000 FRANKLIN Square DR Baltimore MD 31. Date filed (Month, Day, Year) JAN 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Harry LUSBA Tonvary 16 3:100 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 7. Age (In yrs. last birthday) NONTH WACK 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 □ F Months Hours Min 217-09-2872 June 9, Director 87 Maryland 1920 Usual Residence of Decedent 10c. City, Town or Location Show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 ☐ Yes 2 No MDBaltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 7424 Rockridge Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 unk (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 12 n and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Independence Lusby Anna Corrine Reid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Wuanita Lusby/spouse 7424 Rockridge Road Baltimore, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature de uneral Service Lie Ronald 8. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Ward rector Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease or andition resulting in ath) **Physician** Acoba MIGGERALL /Medical Due to (or as a consequence of): Examiner Factonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed buriel-trai Due to (or as a consequence of): physician a Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No o 9☐Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by been signershould be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performed? 1☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 12908-5 Jenuary 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5310 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar

ORIGINAL

Division or Vital Records, P.O. Box 68760 within 24 hours a

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 24

S. Greene St

29c. License number

Baltmere,

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month 8:20 M Harriet JANUARY Lam 22 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BUINIE Baltimore Washington Medical Center 61en 9. Birthplace (State or Foreign Country) Anne 8. Date of Birth (Month, Day Year) Dec. 15 1931 Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** Months 1 □ M 2 🕱 F Days Hours 215-28-8191 76 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the M-dical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7981 Nollpark Ct. Apt 102 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Public Public Schools filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Sydney A. Smith Lydia Holrien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7981 Nollpark Ct., Apt 102, LeRoy V. Lam (husband) Glen Burnie MD 21061 Jan. 26 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 Glen Burnie, MD 4 Donation 5 Other (Specify) Glen_Haven Cemetery Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhan **Physician** br =1 da /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. the 9□Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records, Ş Q pe 1 Yes 2 No 3 Probably 4 Junknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Direct
completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY 12 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Medica Center don uruie ti mere

Registrar

State

31. Date filed (Month, Day, Year)

JAN 24

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of N	Maryland	-	rtment of F		d Mental Hy	rgiene Reg. No. (2008	01525
	Physicia	ın	1. Decedent's Name (First, Middle, Last)		100	HAM		2. Date of D Month	Day	Year	3. Time of Death 12: 24 PM
	/Medic Examin	10	4a. Facility Name (If not institution, give	street and numbe	er)	CHIV	4b. City, Town, o	r Location of De	JANUA,		ounty of Death	
1	Funeral	G1	THE JOHNS HOP in 5. Social Security Number 6. Se	x 7.	OSPITAL Age (In yrs. las		BALTIN If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bin. (Month, D	rth av. Year)	9. Birth	place (State or Foreign
	Director		220-36-0592	\$M 2□F	67	Yrs.	Worldis	Tiours III	6/30			yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	a-f sh	ctor	MD Baltimo	re		Catons	ville					1 □Yes 2 No
	or 28 be no	Dire	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	intry?
	eath v	Funeral Director	112 Delrey Avenue	12. Was Decede	nt Ever in U.S.	. 13. V	212 Vas Decedent of H		(Specify Yes or N lerto Rican, etc.)	0- 14	USA 1. Race - Ameri	
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fun	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Date	s? ∑ No		Yes, specify Cub ☐ Yes 2 No	an', Mexican', Pu Specify:	ièrto Rićan, etc.)	- 1	Black, White, Specify: 1.71	etc.
Ò	72 hou	sted	15. Decedent's Edu (Specify only highest grad	ication	- 1	(Give i	ent's Usual Occup	during most of t	workina	16b. Kind	d of Business/Ir	
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7 0	filed v Hygie other t	မ လ	17. Father's Name (<i>First, Middle, Last</i>)			Supe	rintende		Name (First, Middle		Constru urname)	ction
yiand	12 should be filed within 'h and Mental Hygiene. 7 is marked other than "r rraumatic event, the Mec	To Be	Clyde F. Lanham_					Minn	ie D'Ann	unzio		
Mary	2 short and h		19a. Informant's Name/Relationship (7	pe. Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Num	ber, City or	Town, State, Zi	p Code)
	Health Health tem 27 other tra		Mrs. Patricia L.	Lanham /	20b. Pla	ce of Dispos	sition (Name of		nsville, Date		Land 21 ation - City or T	
D L	ages ent of nt: If It y or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		ite		natory or other pla irk Cemet	1	121.100	Do 1	timoro	Maryland
gaitimor	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licen		/ Loud		. Name and Addre		Loudon P			
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	Physician /Medical		disease or condition resulting in death)	a Due to (or	SEP as a conseque							2 WEEKS
	Examiner		Sequentially list conditions	h		UMON)A					ZWEEKS
/	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or	as a conseque		14 01 W N					15 YEARS
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2/2C	ficate be executed physician and s the burial-transit	edical		d								
ROX PE	uires that the death certifics signed by the attending ph d be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 🗆 Fetal o	death 3	Ectopic pregnanc	y		25	Bd. Date of delivership	very Day Year
_	the de	ysic	1 Yes 2 No	4⊟Pregnan 9⊟Unknow	t at time of dea	atn 5L	Other (specify) _					
as, r.	requires that the een signed by the nould be detache	ğ	Part II. Other significant conditions of	ŭ	h but not result	ting in the ur	nderlying cause gi	ven in Part I.			e contribute to	the cause of death?
cords		Completed				•					24b. Were aut	topsy findings available
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Иai	rsiclan: The law s certificate has b lirector, page 2 s	Be C	25. Was case referred to medical examiner?	Llagaitals			- law		Death (Check only			
000	g Phy ter this neral d	은	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inp 28a. Date of I (Month,		R/Outpatien 28b. Time of Injury	28c. Inju	ry at rk?	g Home 5 Re			ify)
UNISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	injury - At hon , etc. <i>(Specify)</i>	ne, farm, str	M 1 = 1 = eet, factory, office	Yes 2□No	28f. Location City or T	(Street and own, State)	Number or Ru	ral Route Number,
_	Hospital 4 hours al Funeral C	edical Ce	29a. Certifier (Check only) CertifyIng Phy Medical Exam	iner: On the basi	s of examination							
	o the ithin 2 o the o	Medi	one) 29b. Signature and title of certifier	and manner	r stated.	-	29c. Licen	se number		29d. Date	signed (Month	n, Day, Year)
)	- s - ō		Matal MA	Bonis			RE	5-000	2	JANL	LARY 1	9 2008
	J.D.		30. Name and address of person who	ompleted cause of	of death (Item :	23a) (Type,						. ,
	[0		NATAUE M BOWMAN, 7 31. Date filed (Month, Day, Year)	HE JOHNS	MOPKINS	MOSPITA	L. 600 NORT	4 WOLFE	STREET BAL	TIMORE,	MARYLAND	71287
	Sta Registr		18 2 4	2008	istrar's Signatu	F A	1048					

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AM:ND TIEM/19b, perFH, C875 1/24/08, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 15 200 4c. County of Death **Physician** MORROW RuTh 15 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Co Gen Hosp, 5755 HOWERD Cedar Lane olumbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours VIRGINIA 1 □ M 2 🔽 F 062-12-9096 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No HOWARD COLUMBIA MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ROAD, APT. 202 USA 21044 4989 COLUMBIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PSYCHOLOGIST **EDUCATION** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (HARRIET HAYWOOD WALTER DOUGLASS 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 8117 SHERIFF COURT, JESSUP, MD 20794 19a. Informant's Name/Relationship (Type. Print) LEONARD D. MORROW / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 01/22/08 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature uneral Service Licenses 21207 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE, MD Att. Enter the disease, or complications that caused the deplock, or heart ailure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Imm diat ause (Final dise s r condition resu g in death) C **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 24a. Was an autopsy performed certificate | 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After t the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 30641 801 amila 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Neck Road Baltimore Mayland 21221 Ramed Sabapathi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of Mai		epartmen C <i>ertificat</i>				gienę/ Reg. No.	2008	01527
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	Physici		Touce	1000	male	4			Month	Day	2∞8	9:01 Am
	/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or L	ocation of Deal			County of Deeth	
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-	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birth			If Under 24 Hrs	8. Date of Bir	th Vear	9. Birth	olace (State or Foreign
	Director		217-80-5490	м 2 X О F	49 Y	Months	Days	Hours Min	7/20/	1958	MARY	
			Usual Residence of Decedent									
	ylan		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
	the Marylan 28s-f show notified et	to	MD N/A		BA	LTIMORE	CITY					YOXYes 2 □ No
	or 284	irec	10e. Street and Number			10f. Zip	Code			10g. Citiz	en of What Cou	ntry?
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	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show to Marylauf Examine London to Maryl	Funeral Director	11. Marital Status	Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Dece	dent of Hisp	panic Origin? (S , Mexican, Puer	Specify Yes or No)- 1	4. Race - Ameri Black, White,	
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	ould be filed Mental Hygi arked other atic event, II	Be	17. Father's Name (First, Middle, Last)				1		me (First, Middle			
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ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition		20b. Place of I	Disposition (Na., crematory or c	me of	1	Date	20c. Loc	cation - City or T	own, Stete
20	Pages nent of int: If it iry or o		14 Buriai 2 ☐ Cremation 3 ☐ Ri *4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		EM. PAR			/26/08	WTN	DSOR MI	T.T., MD
Baltimore,			21. Signature of Funeral Service License						WELL FU			
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			heart filure. List only on	e cause on each line	. 0	4	0		A			Interval Between Onset and Death
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*	/Medical Examiner		resulting in dealiny	Due to (or as a	consequence o):	+1					
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Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2		3 ☐Ectopic p	regnancy			2	3d. Date of delive	very Day Year
	ne deal the att	icle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		5 Other (s					Month	Day real
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Records,	w requir been si should	Completed							24a. Was		24b. Were aut	opsy findings available
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a	n: Ti licate r. pa		25.04						1 ☐ Yes	No No	1 ☐ Yes	2 No
Vital	iciar certif	Be	25. Was case referred to medical examiner?	ospital:	-		Other	4	ath (Check only			
to	Phys this al di	2	1 Yes 2 No	28a. Date of Injury			UA	4 Nulsing	Home 5 ☐ Res 28d. Describe			ny)
Ę.	ling After uner	lo	1 Natural 5 ☐ Pending	(Month, Day	Year) In	ury M	28c. Injury a Work?	es 2∐No	Log. Doggripo	,,,,,,,		
Division of	tend leath tor: the t	Certification:	2 Accident investigation 3 Suicide 6 Could not be	CO. Disease like					291 Location	(Street and	A Number or Pu	ral Route Number,
≥	or At fter c lirec n by	E	4 Homicide determined	28e. Place of Injur building, etc.	(Specily)	n, street, tactor	у, опісе		City or To	wn, State))	arrioute rumber,
	ital or ral D											
	tosp 4 hou une ely fi	cai	(Check only 2 Medical Examir	sician: To the best of ter: On the basis of e	examination and	death occurred for investigation	t at the time n, in my opii	e, date and place nion, death occ	e, and due to the urred at the time	date and	and manner as place, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner state	ed.							
	To COTT	2	29b. Signatur, and title of certifier	0	0.0	29	c. License	numper	_	290. Date	e signed (Month	, vay, rear)
			1 hagget		/N.D.)47	170	<u> </u>	1/2	-2108	
	d.		30. Name and address of person who co	mpleted cause of de			1	0 07	inne	A 1	Dava	
	5		LIARAT ALI	821	NE	ytaw	Spr	sall	inve	10	1)2/2	0
	Sta	ate	31. Date liled (Month, Day, Year)	32. Registrar	200	Card .						
	Regist	rar	JAN 2 4 2008	14 1 18 m	So A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle Last) 2. Date of Death **Physician** 1:00 A M lan. /Medical 4b. City Town, or Location of Death Examiner limonium Baltimore tospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Days -4200 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , Department of Health and Mental Hygiene. Important: If Item 23a or 28a f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a f show any Injury or other traumatic event, the Medical Ex. miner must be notified at 28a-f show 1 Yes 2 □ No Funeral Director timore 10e. Street and Numb 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Completed by 3 Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) dary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sur Be or Rural Route Number, City or Town, State, Zip Code) Balto. Brother altimore, nod of Disposition ANUARY 1 Burial 2 4 □ Donation Burial 2 Cremation 3 □ Removal from State 5 Opper (Specify) 21. Signatu of F sease, or complications that caused the death. Do not enter the ure. List only one cause on each line 23a. Part1. Enter shock, or hea mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as ed by the attending detached for use as IF FEMALE: f yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown JOHN MARNER signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been signe. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 1 Tyes 2 🗶 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? il or Attending Patter death. 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18-08 Rods 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

DR. EDDIE NAKHUDA

JAN 2 4

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		f Marylan		artment of F		nd Mental Hy	giene Beg. No. 2	008	01530
	Physic	an	Decedent's Name (First, Middle 1. Decedent 1. Deced	. ,					Date of Dea Month		Vear	3. Time of Death
	/Medi		William	S.	Morga	n	Jr.		Januar	y 18,20	08	1:12A M
	Exami	ner	4a. Facility Name (If not institution	-	,		4b. City, Town, or	r Location of	Death	4c. Count	y of Death	
	· posterio constitu		Baltimore Washi				Glen I	_			Arun	
Ċ	Funeral Director		5. Social Security Number 218-12-2761 Usual Residence of Decedent	6. Sex 12 M 2 □ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2- Hours	Min. 8. Date of Birth (Month, Da) July 19	, 1924	9. Birthp Coun	lace (State or Foreign htry) MD
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	ocation			-	1	0d. Inside City Limits
	Mary -f sh	ţ	MD Anne A	rundel	G1e	n Burn	ie					1 ☐ Yes 2X No
	with the Marylan a or 28a-f show be notified at	irec	10e. Street and Number		020	II DULL	10f. Zip Code			10g. Citizen of	What Coun	try?
	th with 23a o	립	113 Olen Drive				21061			U.S.A		
	death v	Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.	Was Decedent of H	ispanic Origi	in? (Specify Yes or No- Puerto Rican, etc.)	14. Ra	ce - Americ	
9	after or ite	교	1 ☐ Never Married 2 🗓 Marr		2 No	- 1	1 ☐ Yes 2 ☐ No	Specify:	Pueno Rican, etc.)		ick, White,	
93	72 hours after death with the Maryland 'ratural', or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:		TES ZLANO	зресну.		Speci	fy: WIII	
21215-0036	72 h "natu dica	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most o	of working	16b. Kind of E	Business/Ind	fustry
121	within ene. than " he Mec	E G	Elementary/Secondary (0-12)	College (1	-4or 5+)			1)		A FILE FIL		
2	iled v Hygie ther t	දි	17. Father's Name (First, Middle,	Last)		Super	VISOI	10 Mathad	s Name (First, Middle,	AT&T		
aŭ	lid be f lental f ked of ic eve	Be	William S. Mor	•					, , ,		me)	
Ž	2 should be and Mental Is marked (raumatic ev	ဥ	19a. Informant's Name/Relations			10h Maili			Lla C. Nowe			
Maryland	iges 1 and 2 should be filed within 72 hours after dea to f Health and Mental Hygiene. If item 27 is marked other than "naturar", or items or other traumatic event, the Medical Examiner m		Mrs. Jeannette		Ji fo				or Rural Route Numbe			Code)
	1 and Health em 27		20a. Method of Disposition	Horgan /v					Burnie, M	20c. Location		nun Ctoto
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		1 ☐ Burial 2 X Cremation	3 Removal from S	State i		osition (Name of matory or other place		Tan. 20,		•	
Ε̈́	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (S		Che	-	ke Cremat			Stevens		
Ba	permi Depa Impo any ir		1 fla	_	MOIY	// S	ervices 1	2nd A	Singleton Evenue SW G	len Bur	L & Cr	emation MD 21061
	Physician		23a. Part1. Enter e disease, or shock, or he rt failure. List Immediate Cause (Final disease or condition resulting in death)		aused the death ach line.		er the mode of dyin	g, such as c	ardiac or respiratory and	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		, ssaming in accum,	Due to (or as a consequ	ce of):	1					
*		<u></u>	Sequentially list conditions,	b. Due to f	or at Conseque	Lence of).	MSTON		745			years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	5	Tree 0	ence on.	MA = (200	*, 0			11000
	certificate be executed iding physician and ise as the burial-transit	xar	that initiated events resulting in death) Last	c. Due to (or as a consequ	ience of):	* WEX	000	щ			year)
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687	ficate phys s the	ö		d								
Box (uires that the death certifics signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come pf pregnar	ncy				00d D		
ă	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	ciar	in the past 12 months?	1☐Live bi	irth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)				ate of delive onth	ny Day Year
O.	the c y the tchec	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno								
σ.	that red b deta	급	Part II. Other significant condition	ns contributing to de	ath but not resu	Ilting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
rds	quires n sign lld be	d by							1 □ Y	es Ž X No	3 Proba	ably 4 □Unknown
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Re	he la e has ige 2	E							autop	sy	prior to con	osy findings available npletion of cause of
Vital	ificat or, pe		25. Was case referred to medical						1 Yes	2 No	1 ☐ Yes	2. No
>	ding Physician: The law requir n. After this certificate has been si funeral director, page 2 should	00	examiner? 1 ☐ Yes 2 📉 No	Hospital:	npatient 2	ER/Outpatien	t 3 DOA Othe	ar.	f Death (Check only or			
9	y Phy er this eral d	2	27. Manner of Death	28a. Date o	of Injury	28b. Time of	1 3LI DOA	4 LI Nurs	ing Home 5 Resid)
Division	Attending r death. ector: Affel by the fune	Certification:	1 Natural 5 □ Pending 2 □ Accident investig	1	h, Day Year)	Injury	Work	t? Yes 2 ∐ No		,,		
isi/	I or Attendi after death. Director: A I in by the fu	lica	3 Suicide 6 Could r	nod Zee. Place	of injury - At hor	me, farm, str	eet, factory, office		28f. Location (S	treet and Numi	ber or Rural	Route Number
Ö	after after d in t	ert	4 ☐ Homicide determi	buildin	ng, etc. (Specify)			City or Town	n, State)		, real of turned,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifyin Medical	g Physician: To the Examiner: On the ba and mann	isis of examinati	vledge, death ion and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, death	place, and due to the coocurred at the time, o	ause(s) and m late and place,	anner as sta and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	and mailti	- outou		29c. License	number		9d. Date signe	ed (Month 1	Dav. Year)
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	~		30 Name and address of norces	who completed serve	of death	229) /Time	Print\	15/1	7 1)	anison	118	2008
11	, 1	- 10	30. Name and address of person	di Cause	or death mem	C S a	in Hipho	10:	Sult sal	(man)	R	L CIN of
	Sta	te	31. Date filed (Month, Day, Year)	Re Re	egistrar's Signet		WI TILL ON G	very	74115-00	YXLH	1 July 1	14 1000
	Registr	ar	JAN 2 4	ZUUX	Will So	1900		Ţ				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01/17/2008 Clinton Martin 7:58 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Riderwood Village Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1**⊠**M 2□F 82 219-16-1613 12/28/1925 DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 √Yes 2 No Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1209 Pickering Circle 20774 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Yes 2 f Yes, Give 2 No Specify: Black 1 ☐ Yes 2 ☒ No Snecify. 3€ Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark Emmanuel Martin Addie Savoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 1209 Pickering Circle, Upper Marlboro, Md Paula Martin / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Cem. 01/25/08 Landover, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Ronald Taylor II Funeral Hm. ronale 108 West North Ave.Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): ALZHEIMERS DISEASE Sequentially list conditions if any, the ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PROSTATE CANCER Due to (or as a consequence of) IF FÉMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes X☐ No Hypertension 24a Was an Hyperlipidemia 1□ Yes 2 No 26. Place of Death Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical **Examiner**

and

certificate

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s after death.

I Director: After this d in by the funeral d

To the Hospital o within 24 hours aft To the Funeral Di completely filled

or Attending Physician:

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

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Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

72

anould be file and Mental Hw

of Health

Department of Important: If it any Injury or o

Pages

burial-trai attending physician for use as the burial Physician/Medical the as signed by the a page 2 s Be

Completed by

Certification: To

Medical

requires that the death certificate be executed

Box 68760,

o

م

or Vital Records,

Division

Examiner

23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown
O B CHILIOWIT

Coronary Artery Disease

25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

1 Inpatient 2 ER/Outpatient 3□ D0A 28b. Time of 28c. Injury at Work? Injury

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

3☐ Suicide

29a, Certifier

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Kleyon

D44156

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexion

State Registrar

08-00639

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark L McBride	State of Maryland / Department of Heal 1-For State Certificate of Deal Registrar	th	Reg. No. 2008 0153
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of De Month	
7	,	Town, or Location of Death more	4c. County of Death
Funeral Director	216-08-2132 1KM 2 F 36 Yrs. Mon	La Dana I Harris I Man	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) N/A
nd how any cc.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baff rmare		10d. Inside City Limits 1 Yes 2 No
1436 th with the Marylanc time 23a or 28a-f sh the notified at once heral Director		2 1201	10g. Citizen of What Country? Unified States:
er dea	1 Never Married 2 Married Armed Forces? If Yes, specially Yes 2 No	lent of Hispanic Origin? (Specify Yes or Listy Cuban, Mexican, Puerto Rican, etc.) No specify:	No- 14. Race - American Indian, Black, White, etc. Specify: Black
5-0036 ed within 72 hours aft bygiene. other than "natural" the Medical Examine Completed by	Lor Dates:	Occupation (Give kind of work done orking life. DO NOT use retired)	16b. Kind of Business/Industry Golf Club
21215-0036 build be filled within 7 Mental Hygiene. marked other than to event, the Medica	17. Father's Name (First, Middle, Last) George Mc Bridge	18.Mother's Name (First, Middle	0 11
MD 21 nd 2 should it alth and Mer m 27 is mar raumatic eve	Garge Mc Bride - Father 5309 1	odd Ave i Balt	
Baltimore, MD 21215-C permit. Pages I and 2 should be filled to Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensys		Randollstown MO
Physician M-di_l (aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the modifallure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic Intoxication	Fredholton Pass	arrest, shock, or heart Approximate Interval Between Onset and Death
iner	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
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certifica nding pl		h 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
ds, P.O. B. equires that the de seen signed by the build be detached if		3	
Vital Records, hysteian: The law require this certificate has been significated as been signification; page 2 should be To Be Completed	25. Was case referred to medical		prior to completion of cause of death? 1 ✓ Yes 2 No
n of Vita ing Physicia After this ce funeral direct	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	DOA Other Nursing Home 5 28c. Injury at Work? 28d. Describ	Residence 6 Other: be how injury occurred
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendible of the funeral director, page 2 should be detached for the deficed of the following the funeral of the following the f	Natural 5 Pending Investigation 3 Suicide 6 XX Could not be determined 4 Homicide Found 1/23/08 Found 5:50am 28e. Place of Injury - At home, farm, street, factor (Specify) dwelling	ry, office building, etc. 28f. Locatio	on (Street and Number or Rural Route Number, City n, State) 746 W Saratoga St.
Divis To the Hospital or A within 24 hours after To the Funeral Direct pletely filled in Medical Certific	Certifying Physician: To the st of my knowledge, death occurred at to one) 2 Medical Examiner: On the sis of examination and/or investigation, in and manner stated.	my opinion, death occurred at the time, de	ate and place, and due to the cause(s)
O KHAN 2	29b. Signature and title of certifier 20b. Signature and title of certifier 30. Name and address of persol-who completed cause of death (Item 23a)	9c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 23, 2008
State	David Fowler M.D. Chief Medical Examiner 111 Penn Street,	Baltimore, MD 21201	
Registra	The second secon	<i>3</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANDRE MOORE 3.15PM January 16 2002 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months 1 2 M 2 □ F Hours **Director** 080-55-6152 New York Sep 25, 1963 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Baltimore 1 T¥es 2 □ No Directo N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A 862 Bridgeview Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Never Worked** Disabled permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Moore Louis Moore ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 862 Bridgeview Road Baltimore, Maryland 21225 Lillian Haskins Mother Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/24/08 Windsor Mill, Md. King Memorial Park 21. Signature Juneral Service Ucen 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 88 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ■ No 24a. Was an 1∐ Yes 2 🔼 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient P 1 Minpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 16 2008

State Registrar 31. Date filed (Month, Day, Year)
JAN 2 4 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. Mamatha Prabhakas, 3001, S. Hanoves street, Baltimore, MD - 21225

RES 000

Certificate of Death

MEYER

2. Date of Death

JANUARY

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2008

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1. Decedent's Name (First, Middle, Last)

MAURICE

Physician

Funera

Directo

/Medical

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) / /-	Dans	/						DO	057	634			JA	NUARY 1	9,	2008	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)																	
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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) JAN 2 4

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** /Medical Town, or Location of Death Examiner powie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05.05. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 **V**F Yrs. Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show ms 23a or 28a-f shormust be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 2071 USA 23a 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 ò 2 3 ☐ Widowed 4 ☐ Divorced "natural"; Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medic el once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ther's Name (First Middle Last Be 2 19b. Mailing Address 5905 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 3 ☐Removal from State 21. Signatur of Funeral 3 ervice Licensee sease, or complications that caused the death. Approximate Interval Between 23a. Part1. Enter the of shock, or heart fail Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 **N**O 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person Detense Itwy

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		State Registrar		•	rificate of Death	Reg	3. No. 2 1 1 8	0153		
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		30. Name and address of person who completed cau	se of death (Item 23)	570/	y Charle	S ST Par	VSON MO	21204		
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08-00448 Gary Newberger	Please	e Type or Print i		lible Ink. Ensu nent of Health a			gible.			
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Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr	4 Donation 5 C	Other Specify:		H HILL HEBRE		23/2008				
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ted Insit			a consequence of):							
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760, cate be physic he bur	IF FEMALE:	23c. If yes,	7.perME.g876 outcome of pregnance	<u>. 2/20/08 TT</u> v			23d. Date	of delivery		
68/ certifu	23b. Was decedent pregn past 12 months?	,	birth nant at time of death	2	Ectopic preg	nancy	Month	Da	y Year	
Box 68760, edath certificate by the attending physic of for use as the burnvisician/Mec	1 Yes 2 No 9	Unknown g Unkr		5 Other (Specify)						
hat the ed by the etache	O to the state of								ne cause of death?	
S, P uires th n signe id be d						1	- 1953		bly 4 🗸 Unknown	
ord aw req as bee 2 shoul	<u> </u>					24a. Was auto	psy	prior to co	ppsy findings available mpletion of cause of	
Records, The law requires ficate has been signate has been signate by the completed Completed						1 ✓ Yes	ormed? 2 No	death? 1 ✓ Yes	2 No	
ital iician: s certif irector,	25. Was case referred to examiner?		26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:							
of Vi g Physi ter this eral dir	1 ✓ Yes 2 27. Manner of Death	No 28a, Date	e of Injury 28b		ijury at Work?		Residence 6			
Division of Vital Records, P.O. Box 68760, strated reads or Attending Physician: The law requires that the death certificate be execute and an arter death. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transer and the completed by Physician/Medical Institication: To Be Completed by Physician/Medical	1 X Natural 5	Pending (Mont	h, Day,Year)		Yes 2 No		,,			
Division tal or Attend as after death at Director: led in by the extification or attification	2 Accident 3 Suicide 6	28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Number of Rural							al Route Number, City	
ᅜᇎᇎᇎᇎ	4 Homicido	determined (Specify)			I G. TOWII,	J. G. C.			

Divis
To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) State

111 Penn Street, Baltimore, MD 21201

(Specify)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Registrar

Medical Certif

4

Homicide 29a. Certifier (Check only one) 2

2 🗸

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

January 17, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Georgette С. Olevich 4:30 AM 20 2008 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 213 Hazel Avenue Lansdowne Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 □ M 2 🛚 F 79 Jan 9, Director Maryland 218-22-1550 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐Yes 2 No Director Md. Caroline Greensboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25644 Zacharias Mill Rd. 21639 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ 3 Widowed 4 □ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) than College (1-4or 5+) Secretary Textile Pages 1 and 2 should be filed vent of Health and Mental Hygient: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Boecker George Sr. Mrytle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Scott Olevich (son) 25620 Zacharias Mill Road, Greensboro, MD 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 1/23/08 Baltimore Maryland 21. Signature of Funeral Se cvice Li ensee 22. Name and Address of Facility Stallings Funeral Home PA any Ir 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stati Par disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed and P.O. Box 68760, C Due to (or as a consequence of) burial physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the a 9∏Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 XYes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 2☐No page certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NOUSC: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending thin 24 hours after death.

the Funeral Director: A pupletely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ave a role Miller MS State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death Month **Physician** /Medical own, or Location of Death 4c. County of Dea Examiner 8. Date of Birth 9. Birthplace (State or Foreign Country) If Under 24 Hrs. . Age (In yrs. last birthday **Funeral** Min. 1 M 2 Months Davs Hours Director Usual Residence of Decedent death with the Maryland 10c. City, Jown or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1⊈Yes 2 No Director Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item any injury or other traumant. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 40USE WATE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOHWKY 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition I Burial 2 □ Cremation 3 □ Removal from State RUZD RIKE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Filer the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme I te Zause (Final disea Condition resulting in death) **Physician** myscondia HOUTE /Medical Due to (or as a consequence of): **Examiner** WAN- DO SCUEDATIO Ocupantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran HALLE CHIMESUSSICH Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical WELLTH 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□ No 3 Probably 4 □Unknown 1 ☐ Yes this certificate has been siral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) ို 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending Investigation (Month, Day Year) Natural 2 Accident M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mits it a gran 1223 31. Date filed (Month, Day, Year) 32. **B**gistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2008

24

				1 - For State Registrar	State of N	Maryland / De	epartment of l Certificate of			giene Reg. No.	008	01540
		Physici	an	1. Decedent's Name (First, Middle, Las	et)				2. Date of De Month	Day	Year	3. Time of Death
		/Medic		William Riley 4a. Facility Name (If not institution, give	street and numbe	nr)	4b. City, Town,	or Location of Death		2 l 4c. Co	2008 ounty of Death	70.00
				Esther's Place Ass			Balti				N/A	
		Funeral Director		5. Social Security Number 6. Sr 093–12–4247	ex 7.7	Age (In yrs. last birtho 85 Yr	Months Days		8. Date of Bir (Month, Da OCT 1	1922	9. Birthe Cour Nort	place (State or Foreign ptry) h Carolina
	Pu	,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					0d. Inside City Limits
	death with the Maryland	28a-f show	tor	MD N/A		Baltir						1 AYes 2 No
	ith the	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cour	itry?
	eath w	ns 23a must	Funerai	5426 Cynthia Ter	race 12. Was Deceder	at Ever in U.S.	2120		pecify Ves or No	_ 14	USA Race - Americ	ean Indian
	036 urs after d	al', or iten Examinat	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	X No	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 XNo		Rican, etc.)		Black, White,	
i	Maryland 21215-0036 od 2 should be filed within 72 hours aft	Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event. The Medical Exant art must be notified at once.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-40	((ecedent's Usual Occu live kind of work done le. DO NOT use retire	pation during most of work ad)	king	16b. Kind	of Business/In	
3	d 21	Hygier ther th		17. Father's Name (First, Middle, Last)		Art	ist	18. Mother's Nam	ne (First. Middle		Arts	
_	vid be	dental irked o	To Be	Unk				Janie	Riley	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	mamo,	
	Mary 12 sho	hand h		19a. Informant's Name/Relationship (7			ailing Address (Stree	t and Number or Rui	ral Route Numb			
	s 1 and	f Healt item 2 other t		Belinda Pringle - 20a. Method of Disposition		20b. Place of D	26 Cynthia sposition (Name of crematory or other pla		Date Date		D 2120 tion - City or To	
	Baltimore, permit. Pages 1 ar	ment o ant: if ury or		1 ☐ Burial 2 X Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify))	.0	rematory,	Inc. 1/23	/2008	Balt:	imore,	MD
	Ball permit.	Depart Import any inj once.		21. Signature of Funeral Service Licen	H Will	iams	Cremation 299 Fred	ess of Facility n Society erick Road	of Mary	yland, imore,	Inc.	1228
		Щ.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus one cause on each	ed the death. Do not line.						Approximate Interval Between Onset and Death
		ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	as a consequence of)	rtcon				2	1 week
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	U, vexecuted	ician and burial-transit		that initiated events resulting in death) Last	C. Due to (or a	is a consequence of):			·			
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	Hecords, P.O. Box 68/60 The law requires that the death certificate be	attending ph	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No		ne of pregnancy 2 Tetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify)	y		23d	. Date of delive	ery Day Year
	at the c	by the	hysic	1 Yes 2 LA No 9 □ Unknown	9□ Unknown		Other (specify)					
5	rdS, P	been signed I should be det	ed by P	Part II. Other significant conditions of	entributing to death		e underlying cause gi	ven in Part I.	23e. Did to	1		ne cause of death?
O c	I KECOFO The law requir	has je 2	ompleted						24a. Was autop perfo 1 \sum Yes		4b. Were auto prior to cor death? 1 \(\subseteq \text{Yes}	psy findings available npletion of cause of
-	OT VITAL	certific rector,	BeC	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Deat	th (Check only o	one)		Esther's
, 9	g Phys	C	n: To	27. Manner of Death	1 ☐ Inpat 28a. Date of In (Month, D		e of 28c. Inju	her: 4 Nursing Hory at	ome 5 Residence 128d. Describe 1			Asstel
7/	SION	eath. or: After the funer	ertification;	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		<i>ay Year)</i> Inju		Yes 2 No			28	31 Montebell
Nil	UIVISION I or Attending	Direct Direct In by	ertifi	4 Homicide determined	288. Place of I	njury - At home, farm etc. <i>(Specify)</i>	street, factory, office		28f. Location (5 City or Tov	Street and N vn, State)	lumber or Aura	l Route Number,
3	e Hospita		edical C	29a. Certifier (Check only one) 12 Certifying Phy	vsician: To the besiner: On the basis and manners	st of my knowledge, d of examination and/o stated.	eath occurred at the tr r investigation, in my o	me, date and place, opinion, death occur.	and due to the red at the time,	cause(s) and date and pla	d manner as st	ated. the cause(s)
	Toth	Mithir To th COMP	Me	29b. Signature and title of certifier M. M.	Mebre	ey	29c. Licens	se number	7	29d. Date s	igned (Month,	Day, Year) 2008
	H			30. Name and address of person who co	LCNEB	death (Item 23a) (Ty	Print) 4640	Eeste	irn A	re	Balte	1 2008 2008 21224
		Star Registra	_	31. Date filed (Month, Day, Year) JAN 2 4 20	64.	trar's Signature	Carte					
	DHMH	17 Rev 1/20	10	OHN W I CO	00	7						

			1 - State Registrar	or waryland		tificate of		MEHIC	, ,	1. No. 2	08 01541
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Dat	e of Death	- Las W	3. Time of Death
	Physicia /Medic		Frank Alonzo Rolle					-	wary		008 1425 PM
	Examin	er	4a. Facility Name (If not institution, give street and	*		_	, or Location of Dea	ath		4c. County o	
		101	Sinai Hospital of Battin 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast hirthday)	Baltimo If Under 1 Yea	,	S. 8 Dat	e of Birth		N/A 9. Birthplace (State or Foreign
	Funeral Director		124-26-1934	-	3 Yrs.	Months Day			e of Birth onth, Day, Y		Country)
	D		Usual Residence of Decedent					TIA	L 4/ .	1734	South Carolina
	arylan show d at	Į.	10a. State 10b. County		, Town or Loc						10d. Inside City Limits
	he Ma Ba-f s	ecto	MD Baltimore	Ra	andalls						1
	with t	Dir	10e. Street and Number			10f. Zip Code			100	g. Citizen of W	hat Country?
	after death with the Maryland after death with the Maryland or items 23a or 28a-f show miner must be notified at	Funeral Director	8601 Grey Fox Road 11. Marital Status 12. Was D	ecedent Ever in U.S	s. 13. W	211		Specify Ye	s or No-	USA 14. Race	- American Indian,
Ju	after o		1 Never Married 2 Married 1 Ye	l Forces? es 2 ☐ No			f Hispanic Origin? Jban, Mexican, Pu	eno Rican,	etc.)		, White, etc.
FRANK	ours a	d by	3 ☐ Widowed 4 ♣Divorced If Yes,	Give or Dates: 55–62	_ 1	□Yes 2MIN	o Specify:			Specify:	Black
THE PERSON NAMED IN	72 hours "natural";	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	16a. Decede (Give k	ent's Usual Occ	upation ne during most of w red)	orking	16	6b. Kind of Bus	siness/Industry
2 5	within lene. than "	ldm	Elementary/Secondary (0-12) Colleg	e (1-4or 5+)						0.16	n 1 1
Son	filed v Hygie	ပိ	17. Father's Name (First, Middle, Last)		Mainte	enance V	18. Mother's N	ame (First.	Middle, Ma		Employed
Rollerson,	lid be Sental Ked o	To Be	Frank Rollerson				Marv	,	dner		,
CL	should in Men warke	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailing	g Address (Stree	et and Number or			City or Town, S	State, Zip Code)
2	1 and 2 Health s tem 27 is		Anthony Rollerson - so	n	3345	Reservo	ir, Oval	W, Bı	conx.	NY 104	67
5	of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from	20b. Pl	lace of Dispos emetery, crem	sition (Name of natory or other p	lace)	Date			City or Town, State
<u> </u>	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Specify)	Met	ro Crei	matory,	Inc. 1/2	24/200	08 1	Baltimo	re, MD
o di mi	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I filmportant: If fine 72 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee H. W	lilliams	²² C	Name and Add rematio	ress of Facility on Societ lerick Ro	y of	Maryl	and, In	nc. D 21228
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death	. Do not ente	r the mode of d	ying, such as card	ac or respi	ratory arres	st,	Approximate
لم	Physician		Immediate Cause /Final	Congestive	heart	failure	2,				Interval Between Onset and Death
	/Medical		resulting in death)	to (or as a consequ		1-54(00)					6 days
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ď	w requires that the de been signed by the should be detached	δ	Part II. Other significant conditions contributing to	o death but not resu	iting in the und	denying cause o	given in Part i.	23			bute to the cause of death?
Š	requi	Completed	Acrtic regurgitation	_				-		2 110	3 Probably 4 □Unknown
Š	has the 2 s	mpl	Chronic renal insuffic	,				- 24	 a. Was an autopsy performe 	ld l	Vere autopsy findings available nor to completion of cause of
-	iclan: Th certificate ector, pag		Coronary artery di	sease					Yes 2	THO 1	eath? □Yes 2☑No
5	ysician: The is certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	La fripatient 2 □ E	ER/Outnationt	3□ DOA C	26. Place of D				(0
Olivicion or Vital Becarde D O Box	g Phy er this eral d	n: To	27. Manner of Death 28a. Da	ate of injury Month, Day Year)	28b. Time of	28c. In	4 🗆 Nursing			ice 6 Gothe	
2	ath. rr: Aft	Certification:	1 ☑ Natural 5 ☐ Pending (M 2 ☐ Accident investigation	nonth, Day Year)	Injury		rork? □Yes 2□No				
2	r Atte er de recto	tific	3 Suicide 6 Could not be 4 Homicide determined 28e. Pl	ace of injury - At hou	me, farm, stre	et, factory, offic	e	28f. Loc	cation (Stre	et and Numbe State)	r or Rural Route Number,
	Ital or A ral Dire	Cer									
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours affect death. To the Luneral Director. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To 2 ☐ Medical Examiner: On the and n	the best of my know ne basis of examinat nanner stated.	wledge, death tion and/or inv	occurred at the estigation, in m	time, date and pla y opinion, death oo	ce, and du	e to the cau ne time, da	use(s) and mar te and place, a	nner as stated. nd due to the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	nse number		290	d. Date signed	(Month, Day, Year)
			Peter W. Cho,	surgeon		104	11129		L	anuary	20, 2008
	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		30. Name and address of person who completed c	ause of death (Item	23a) (Type, P	Print)	72 115		, .	7	
	17		Peter W. Cho, Sin 31. Date filed (Month, Day, Year)	ai Hospital	of Bat	timore,	Balthure	Mary	land	61215	
	Sta Registr		JAN 2 4 2008	2. Registrar's Signat	Asset.	K)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:30 P^M Denise Louise Redington January 19, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8347 Mary Lee Lane Laurel Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 28, 1969 Director 38 Oct Maryland 215-82-1236 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County show 10a. State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20723 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral 8347 Mary Lee Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White Specify. If Yes, Give Year or Dates: ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Government Computer Analyst 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen Wayne Dellinger Louise P. Lockhard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8347 Mary Lee Lane, Laurel, Maryland 20723 Gregory V. Redington /spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory Jan 23, 08 | Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signay re f Funeral Ser M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 Approximate Interval Between Onset and Death 23a. Part1. Enter the useese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beary/ailure. List only one cause on each line. Immediate Cause Find disease or condition resulting in death) Renal Failure **Physician** years /Medical Due to (or as a consequence of): Examiner Vasculitis vears Sequentially list conditions, if any, leading to immediate Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 2 XNo 1□ Yes 1 ☐Yes 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: (Month, Day Year) Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death i Director: d in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) e of certifier Vanny Lee, my D54853 January 22, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Danny Lee, MD

JAN 24

31. Date filed (Month, Day, Year)

Odenton, MD

Annapolis Road,

32. Signature

1132

2008

Baltimore, Maryland 21215-0036	bermit. Pages I and 2 should be lifet within 72 hours alter ueath with the marytanio. Department of Health and Mental Hygiene. Innoctant: If tem 27 is marked other than "natural" or items 23a or 28a-f show	any injury or other traumatic event, the Medical Examiner must be notified at
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Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and sthe burial-trans Division or Vital Records, P.O. Box 68760 attending pl this certificate After 1

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 6:40 \mathbf{A}^{M} 23 JANUARY LAURA ROYAL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cherry Lane Nursing Center Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🔀 5, Virginia 1926 81 228-28-3521 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2√ No Director Howard Laurel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 9720 Covered Wagon Drive, Apt. E 20723 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 【No Specify: Black If Yes, Give Year or Dates: δ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20723 9720 Covered Wagon Drive, Apt. E, Laurel, MD James Peter Gunn/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Odenton, MD West Arundel Crem. 1/25/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M01103 | anul 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cuse on each line. Approximate
Interval Between
Onset and Death
Over 2 years Immediate Carse (Final Cancer of Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day in the past 12 months? 1 ☐ Yes 2 K No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXVInknown Dementia and Psychosis Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2ᡌ No 24a. Was an autopsy performed? res 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient P 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 23, 2008 D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20708 14333 Laurel-Bowie Road, Suite 208, Laurel, MD Syed Sadiq,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4

2008

32. egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01/23/2008 **Physician** Arma Marie Repetti 5:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours 372771909 1 □ M 2XX 216-03-9492 98 Director MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes XXNo Director MD Carroll Woodbine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5707 Manor Dr. 21757 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ♣★No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: White 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her Home Pages 1 and 2 should be filed wi frnent of Health and Mental Hygier tant: If item 27 is marked other th jury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosario Falise Rosa Valenzia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Repetti/Son 12009 Metee Rd., Marriottsville, MD 21104 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or 4 Donation 5 ther (Specify) Entombment Druid Ridge Cemetery 1/28/2008 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.
Burrier-Queen Funeral Home & Crematory, P.A. any 1212 W. Old Liberty Rd., Winfield, MD 21784 Part | Enter the disease, or complications that cay sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. medicte Cause (Final 6 YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2114 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 | Inpatient 2 ER/Outpatient 3∏ DOA Certification: To nours after death.

Ineral Director: After this it filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 2 4 State Registrar

DHMH 17 Rev 1/2001

08-00542 Destiny Honeycut	1	Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental Hy For State Legistrar Certificate of Death	/giene		8 0154
Physiciar	1/	Decedent's Name (First, Middle,Last)	2. Date of De Month	ath Day Year	3. Time of Death 1000 hrs
Medical Examin	■.	Destiny Alexis Rhodes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month January	19, 2008 4c. County of Death	
		Anne Arundel Medical Center Annapolis		Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24Hrs. $ 212 - 81 - 1301 $ 1 M $2\overline{X}$ F Yrs. 1 1 Days Hours Min.	_	irth (MM/DD/YYYY) 9. Bir Foreig 7 , 2007	
		Usual Residence of Decedent			Land Living Other Limits
w any	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 X No
yland a-f sho	흱	MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code	Т	10g. Citizen of What Cou	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	617 Old Stage Road 21061		U.S.A.	,
with th	ᇹ	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or N	lo- 14. Race - Amer	ican Indian, Black,
death death	<u> </u>	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ral", o		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	work done	Specify: WII	ite
2 hour "natu	흵	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the control of		Tob. Kind of Business	industry :
036 thin 7 ne.	Completed by	0 N/A		N/A	
5-0 lled wi Hygie I other			•	, Maiden Surname)	
d be fi tental tarkec	8	Jay Brian Rhodes Jr. Jennife: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		Honeycutt	a Zin Code)
1D 2 2 shoul 1 and N 27 is n	ို	Jennifer Honeycutt/Mother 617 Old Stage Road G			
e, N 1 and 3 Health item ;	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date n. 24,	20c. Location - City o	
mor Pages ent of nt: If			008	Glen Burn	ie, MD
altir	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sin			
	Ì	Services 1 2nd Aver			, MD 21061 Approximate Interval
Physician Mucical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexplained death in infancy (SUDI)	or respiratory a	arrest, snock, or near	Between Onset and Death
X	-	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):			
	횰	if any, leading to immediate Due to (or as a consequence of):			
	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	ШΙ	d.			
be exe	8	X UNPENDED #23a,27,28a-f, perME,0877 3/10/08 TT #1_perME,0875 1/24/08 TT			
P.O. Box 68760, that the death certificate be execut to by the attending physician and detached for use as the burial - translet.	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	ancv	23d. Date of delive Month	ry Day Year
x 68 h certi	冟	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	unoy		
Bo ne deat the at	Phys	1 Yes 2 V No 9 Unknown g Unknown	Loo - Die	A to be a constant to the state of the state	a the same of dooth?
(A) (A)	হ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 🔲 ነ	d tobacco use contribute t	obably 4 🗸 Unknown
ords w requ	Completed			topsy prior to	utopsy findings available completion of cause of
Recol The law icate has	Ē			rformed? death? s 2 No 1	personal per
Vital F ysician: his certifi	Be	25. Was case referred to medical examiner? LHospital: 26. Place of Death (Check			
n of Vital Rec ing Physician: The After this certificate uneral director, page	ို	Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Wish	ng Home 5	Residence 6 Oth	er:
on one on one one	<u> ë</u>	1 Natural - (Month, Day, Year)	unk		
risic r Atter er dear irector	ligat 	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location	n (Street and Number or F	Rural Route Number, City
Division of N Hospital or Attending Ph 24 hours after death. Funeral Director: After telly filled in by the funeral	Certification:	Suicide 6 XCould not be determined (Specify) other scene	or Town	, state) erman Ct. Steve	nsville, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the ca	ause(s) and manner as st	ated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the title, Ga	29d. Date signed (M	

State Registrar

DHMH 17 Rev 1/2001
OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Zabiullah Ali, M.D.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 20, 2008

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien UU8 1 - For Stata Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month SULLIVAN **Physician** ERNON 0752 22 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ARBOK BALTIMORE Baltimore 474 HOSI ITA L If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. | JAN 28 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 5. Social Security Number **Funeral** Months Maryland 216-36-0597 66 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County items 23e or 28e-f show other treumetic svent, II e Madical Exactiner must be notified at 1 ☐ Yes 2 No Director Halethorpe MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1953 Bell Avenue 21227 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 ö 1 Yes 2 X No Specify þ 3 ☐ Widowed 4 ☐ Divorced "neturel', Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h Pages 1 and 2 should be Sullivan **Viola** Parker William Agnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 i Rosemary Sullivan - Wife 1953 Bell Avenue, Halethorpe, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ö permit. Page Department of Importent: If any injury or once. Metro Crematory, Inc. 1/23/2008 21. Signature of Funeral Service Licensea 22 Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road, Baltimore, MD Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCV 10 years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records. 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 Yes 2 - No certificate To the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Nes 2 No 2 R/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 1 ☐ Yes 2 ☐ No М death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 \ Homicide hours after Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 24 one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

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32. Segistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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NOA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 01 12:15 PM VERNETTA SAMPSON 14 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Manor Care Potomac Potomac 8. Date of Birth (Month, Day, Year) 08–14–1945 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) Min. Months Days Hours North Carolina 1 □ M 2 🔀 F 62 240-72-9387 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County MD Montgomery Potomac XXYes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20854 10714 Potomac Tennis Lane Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2/□No Specify: Specify Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Nelson Jasper T. Sampson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 14508 Danube Lane, Mitchellville, MD 20721 Angli Black Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Riverdale Park Crematory 01/17/2008 Riverdale, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servi Wash, DC 20011 Bianchi 814 Upshur St NW 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE SCLEROSIS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 2 must be n

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland Hygiene.

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

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24 hours after death. • Funeral Director: A

within 24 hor To the Fune completely fi

burial-tran physician a as ed by the a detached f signed by t certificate has been si rector, page 2 should

Physician/Medical Pa þ Completed 25 funeral director, Be Certification: To filled in by

rt II. Other significant conditions	contributing to death but not res	23e. Did tobacco us	23e. Did tobacco use contribute to the cause of death?									
				1 ☐ Yes 2 💆	No 3 Probably 4 Unknown							
				24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 (♣ No							
. Was case referred to medical		26. Place of Death (Check only one)										
examiner? 1 ☐ Yes 2 ☐ ☐ O	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	ome 5 ☐ Residence 6	☐Other (Specify)								
7. Manner of □ eath 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 Suicide 6 Could not determined		ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
9a. Certifier 1 Certifying F	Physician: To the best of my kno	owledge, death occurre	ed at the time, date and place	, and due to the cause(s)	and manner as stated.							

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00057124

29d. Date signed (Month, Day, Year)

1/23/08

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suite201 Rockville, MD 20850 9715 Medical Center Dr. Truong Boa

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

un Ben, lyo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per dr., g875,01/2/4/08dhb/f Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sher 1000AM Sylvia 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltmore Lumernile 11504 Wovaland Dr. Birthplace (State or Foreign Country)
 NY If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 85 12/24/1922 217-16-0758 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 725 MOUNT WILSON LANE, APT. #227 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1□Yes 2XINo WHITE Baltimore, Maryland 21215-0036 Specify: þ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other transment." Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **AARON** GOLDBERG SARAH KERTZER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 WINE SPRING LANE, BALTIMORE, MD 21204 JOEL SHER / SON 20b. Place of Disposition (Name of ARPITY NETTONY or OTHER LIKE AMUNO CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 01/20/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licepoce 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastanc hnast concer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-trar Due to (or as a consequence of) Division or Vitál Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknowr signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ hypertonsion 2 No 3 ☐ Probably 4 ☐ Unknown Completed nypernyvidism 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s deep venous moum posy 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be examiner? Son's Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence Manner of Deal 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: A death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000000000 19/2008 W

31. Date filed (Month, Day, Year) JAN 2 4 2



State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WINDER 2008 MUSTHT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ACTIMORE OSPITAL N/A FISCA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Dec. 31, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕌 Mary land 212-10-5249 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ∏Yes 2 ☐ No Director Maryland | N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r USA 21230 600 Light St., Apt. 827 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: 9 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than ' mportant: If item 27 is marked other than ' any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Ellen Bucholtz Charles Henry Manner Nancy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3638 Greenvale Rd., Baltimore, MD 21229 Gary E. Swindell (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 1/21/08 Loudon Park Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee. 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1∐ Yes 2 14 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ∏Yes 2 ∏No n 24 hours after death.

ne Funeral Director: A

oletely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PAUL PLACE BACTIMORE MU 21202 40 365E7

State Registrar

31. Date filed (Month, Day, Year)

32. Finistrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00 AM Charles A. Schoenhaar 22 2008 Januarv /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Harbor Hospital 8. Date of Birth

June 20, 1921 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days Min Maryland 1 1 M 2 □ F 86 219 07 3104 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 X No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 510 Church Street U.S.A. 21225 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Department Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Schoenhaar Theresa Knaup ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is in any Injury or other traun once. Baltimore, Maryland 21225 510 Church Street Rita Schoenhaar / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/26/2008 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failback List only one cause on each line. Immediate Cause (Final Physician Meuman disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dement Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hy parra The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has l page 2 s 2 No certificate 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury 1 ☐ Yes 2 ☐ No ours after death. neral Director; A filled in by the fu investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1/23/08 10×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Milleriville wite 211 egistrar's Signat State Registrar

reeman Sanders	State of Maryland / Department of Health and Mental Hygiene 1- Fcr State Registrar Certificate of Death Reg. No. Reg. No.									
Physician Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2082 Adison Road South Apt# 1 Fort Washington 4c. County of Death Prince George's									
Funeral Director	5. Social Security Number 431-32-2435 Age (In yrs. last birthday) 83 Yrs. 6. Sex 7. Age (In yrs. last birthday) 15. Under 1 Year 16 Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Ark.									
Varyland 28a-f show any d at once.	Usual Residence of Decedent 10a. State									
r death with the I or items 23a or must be notifie	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Widowed 4 Divorced or Dates: 1 Never Married 2 Married 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify:									
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner. Commissed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) 12th Truck Driver Private									
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than lie event, the Medica TO Be Comple	Young Sanders Lillie Mae Young									
Baltimore, MD 2121 permit. Pages I and 2 should be if Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	Carrie Henry/Daughter 6120 Lancaster Drive, Flint, Michigan 4852 20a. Method of Disposition 1 x Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: MD Veterans Cemetery Crematory Of the Place of Disposition (Name of cemetery) 4 Donation 5 Other Specify: MD Veterans Cemetery 7-28-2008 Cheltenham, MD									
Balt permit Depart Impor	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral HM 108 W. North Ave. Baltimore, MD 21201									
Physician /Medical :aminer	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):									
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tal Records, tian: The law requires certificate has been signet, page 2 should be Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No									
n of Vir ling Physic After this funeral dir										
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ledical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Homicide Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hos within 24 h To the Fur completely										
	Doma Mincenti, m.D. O.C.M.E. January 15, 2008									
5	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registra	70 N 2 N 1110 1 Se m M 2 2 P									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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Physicia	an/	Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
ledical Exami	ner	David Street	Month Day January 20, 2	008 4c. County of Death	1830 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 501 Dolphin Street Apt. 405 Baltimore		W/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Bir	thplace (State or Foreign
Director		213 - 52 - 25/0 1 Mm 2 F 37 Yrs. Months Days Hours Min.	June 20	200	ary land
,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ow an		m i dia			1/X Yes 2 No
daryland 28a-f show any 1 at once.	cto	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cou	ntry?
the Ma a or 21	Director	501 Dolphin St. Apt 405 21217	4	nited 1	tates
h with ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1) 14. Never Married 2 Married Armed Forces? 15. Marital Status 17. Was Decedent of Hispanic Origin? (Sp. 1) 16. Marital Status 17. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Origin? (Sp. 1) 18. Was Decedent of Hispanic Origin? (Sp. 1)		14. Race - Amer White, etc.	ican Indian, Black,
r death	Fun	1 Yes 2 No	r would be to the	Specify: 181a	. le
irs afte iural", iminei	ò	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	vork done 16t	. Kind of Business/	
5 72 hou n "nat al Exs	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	red)	1	
yo36 within iene. er tha	dmg	12 Laborer		Facto	19
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than c event, the Medical	Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Name David Russell Street Eliza	(First, Middle, Maid	en Surname)	
LD 21215-00; should be filed with and Mental Hygiene. 7 is marked other that it is marked other that is a the Medical control of the Medi	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Number,	City or Town, State	e, Zıp Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once			, St. B.	elto, MI	1213
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If item 27 is marked other than "natural", her traumatic event, the Medical Examiner		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City of	Town, State
Pag Pag rent		1 Dogation 5 Other Specify: A Dogation 5 Other Specify: A Communication of the place of the pl			aun mo
Balti permit. Departir Import		21. Strature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 27. Firedhill 27. Firedhill	Hon Pas	5 F.S.	-MO 21229
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.			Approximate Interval Between Onset and
///_aic_al xaminer		Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease			Death
j.		or condition resulting in death) Due to (or as a consequence of):			1
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
1 -	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ecuted and ransi		d			
60, ate be execut obysician and	Physician/Medical	UNPENDED		22d Date of delive	
1876 rtificat ing ph	M/NE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliver Month	Day Year
Box 687 e death certificathe attending ped for use as the	sicia	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	*****		
i, P.O. Box 687 ires that the death certification is signed by the attending place declared for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
, P.O. res that the signed by be detach	d by		1 Yes 2	No 3 Pro	obably 4 🗸 Unknown
ords,	Completed		24a. Was an autopsy		utopsy findings available completion of cause of
tal Reco	omp		performed 1 Yes 2 ✔		res 2 No
ital Recition: The certificate rector, page	BeC	25. Was case referred to medical examiner?	only one)		
of Vit ing Physic After this c uneral dire	ToE	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Street Nursin	-	idence 6 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending 1 Yes 2 No	28d. Describe how	injury occurred	
ivisior or Atteno after death Director:	ficat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Div pital or ours aft cral Di	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State	·) 	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and cone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and cone)	d due to the cause(s)	and manner as sta	ited. he cause(s)
To the within To the comp	Medical	29b. Signature and title of certifier 29c. License number		d. Date signed (M	
		MAR. O.C.M.E.		anuary 23, 200	
		30. Name and address of person who completed cause of death (Item 23a)			
3		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
St Regis	tate trar	31. Date filed (Month, General 4 2008 32. Restrar's Signature			
	-	The state of the s			

			Please 7	Type or Prin									
			For State Registrar	State of Ma	arylan		artment of rtificate o		and Mental	Hygien Reg. N		3 0	1553
	Physici /Medic		Decedent's Name (First, Middle, Last LIBBY)			SMULOVI	ΤZ	2. Date of Month	n D	ay Year		ne of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give Sirial Hospital of 5. Social Security Number 6. Security Number 113-28-2955 11	Baltim		last birthday) Yrs.	4b. City, Town Balti If Under 1 Ye Months Da	MOTE ar If Under	of Death r 24 Hrs. 8. Date of Mont.	J 4	4c. County of Death N/A 9. Birthplace (State or Foreig Country) MD		
	yland how at		10a. State 10b. County		10c. City	y, Town or Lo	ocation					1	le City Limits
	he Mai 18a-fsl otiffed	ector	MD BALTIM	ORE	B	ALTIMO				T			Yes 2X No
	3a or 2	ij	10e. Street and Number 2 POMONA WEST, #	7			10f. Zip Cod	∍ 1208		10g. C	itizen of What C	-	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:		If Yes, specify Cuban, M 1 ☐ Yes 2 【 No Sp		of Hispanic O uban, Mexica		or No-	14. Race - American Indian, Black, White, etc. Specify: WHITE		
15-0	n 72 h "natu edical	letec	15. Decedent's Edu (Specify only highest grad			i (Give	dent's Usual Oc kind of work do DO NOT use rei	ne durina mo	st of working	16b.	Kind of Business	/Industry	
212	ed withi giene. er thar , the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		HOMEM	,			OWN	HOME	
and	I be file ntal Hy ed oth	To Be (17. Father's Name (First, Middle, Last) WILLIAM		ים	EL VOUT	T-7	18. Moth	ner's Name (First, M.	iddle, Maide	ŕ		
aryl	should ind Me inark mark	2	19a. Informant's Name/Relationship (7)	rpe. Print)	Di.	ELKOWI 19b. Maili		et and Numb	IDA ber or Rural Route N	lumber, City		LLER Zip Code)	
Ž	and 2 ealth a m 27 is		RICHARD SMULOVI	TZ / SON		170	5 BOGGS	ROAD,	FOREST H				
Baltimore,	Pages 1 ment of H ant: If Itel ury or oth		20a. Method of Disposition 1	Removal from State	0	Place of Dispo emetery, crea RODFE	osition (Name of matory or other) ZEDEK	olace)	Date 01/18/200		Location - City o		е
Balt	permit. Depart Import any inj once.		21. Signature — uneral dervice Licens	Pilina	1		2. Name and Ad		JUL LL		& BROS		
ľ			23a. Part 1 Enter the disease, or comp shock, or heart fallure. List only o	ications hat caused	the death				TOWN ROAD s cardiac or respirate		CESVILLE	Approx	
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ary	embol						Onset a	days
1760,	be executed ician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
P.O. Box 687	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	Ideath 3]Ectopic pregna] Other (specify			_	23d. Date of de Month	elivery Day	Year
	quires that n signed by ald be deta	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the u	nderlying cause	given in Part			use contribute t		
Division or Vital Records,	n: The law require icate has been sig r, page 2 should b	Completed								Was an autopsy performed? 'es 2	prior to death?	completion	ings available of cause of
<u> </u>	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗌	ER/Outpatier	nt 3 DOA	Other:	ce of Death (Check of lursing Home 5		6 ∏Other (Sn	ecify)	
ion o	To the Hospital or Attending Physician: The I within 24 brours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry	28b. Time o Injury	f 28c. II	njury at Vork?	28d. Desc		ury occurred	Sony	
DİXİ	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc	c. (Specify	v)		et, factory, office 28f. Location (Street and Number or Rural Route N. City or Town, State)				Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1 ★ Certifying Phy (Check only one)	sician: To the best oner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred at the vestigation, in n	e time, date a y opinion, de	and place, and due to eath occurred at the	the cause time, date a	(s) and manner a nd place, and du	s stated. e to the cau	ıse(s)
	To the within To the complex	Σ	29b. Signature and title of certifier	0 4				ense number		29d. D	ate signed (Mor	th, Day, Yea	ar)
)	. ^		30. Name and address of person who co	Honel	A path /ltar	1D		LES	000	Jav	luciny	16,2	008
	10		Nicole L. Strong		Sino			Baltim	ore, 2401	W. B	elvedere	tre B	ethnikove, M 21215
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 4 2	32. Jegistra	ar's Signa	ture A	as of						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 协 2. Date of Death SHAPIRO Month Day 2008 **Physician** 07.04AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 6. Sex Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1**№** 2□ F 140-28 863 Usual Residence of Decedent POLAND Director 10a. State 10b. County 10c. City, Town or Location ia or 28a-f show t be notified at 10d. Inside City Limits 1 Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3829 LABYRINTH ROAD 21215 USA Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ☐ Divorced Completed the Medica 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education within 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 CAP MAKER & GROCER CLOTHING & RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be fi es 1 and 2 should be Health and Menter item 27 Is marked RUBIN SZAPIRO ROJZE UNOBTAINABLE ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS SHAPIRO / WIFE 3829 LABYRINTH ROAD, BALTIMORE, MD permit. Pages 1 a
Department of Hea
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cepater) cremators pother place)
ANSHE VESHEAR Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/21/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.0. 2 No 9 Unknown 9 Unknown signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has ! page 2 autopsy performed The certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 XNatural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

30 Name and address of person who completed cause of death (Item 23a) (Type

egistrar's

2 4

D54288

29d. Date signed (Month, Day, Year)

TPAVIS, HELEN Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of Ma	aryiano		tificate of I			giene Reg. No.	711119	0155	
cian ical	1. Decedent's Name (First, Midd Helen C. Travi						2. Date of De Month January	Day	y Year 2008	3. Time of Death	
iner	4a. Facility Name (If not institution Laurel Regional H				4b. City, Town, or Laurel	Location of Death			County of Deat		
	5. Social Security Number 023-03-4395	6. Sex 7. Age 1	e (In yrs. las 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov. 23,	ay, Year)	Co	thplace (State or Foreig buntry) achusetts	
tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		10c. City,	Town or Loc	ocation				-	10d. Inside City Limits	
al Director	10e. Street and Number 7700 Cherry Lane,	Apt 319			10f. Zip Code			10g. Citi	izen of What Co	ountry?	
To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		If	Vas Decedent of H Yes, specify Cuba □Yes 21□ No	Ispanic Origin? (Sp un, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh		
Completed		nt's Education est grade completed) College (1-4or 5	+)	(Give I life. D	O NOT use retired	during most of work	ting		ind of Business/	Industry	
To Be Co	17. Father's Name (<i>First, Middle</i> Henry Albert Cassi	•		Homemak	er	18. Mother's Name	e (First, Middle		Home Surname)		
	19a. Informant's Name/Relation. Robert A. Travis-		_,	3289 S	udlersville	e South, La	urel, MD	20724	+		
	20a. Method of Disposition 1										
	23a. Part1. Enter the disease, of		/land 2070	O7 Approximate							
Examiner	snock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last	·	a consequence of some consequence of the consequenc	nce of):						Interval Between Onset and Death	
edical	IF FEMALE:	Due to (or as a d							23d. Date of dei	liven	
Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)				Month Month	Day Year	
b	Part II. Other significant condit	lons contributing to death bu	ut not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did 1			o the cause of death?	
Completed	OF Was and ordered when the						1□ Yes	psy ormed? 2 No	prior to death?	utopsy findings available completion of cause of a 2 No	
Certification: To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Injui (Month, Day) gation not be	ry Year) 2	R/Outpatient 8b. Time of Injury e, farm, stre	28c. Injun Work M 1 🗆 '	4 □ Nursing Ho / at (? Yes 2 □ No	ome 5 Resi 28d. Describe	idence how injur	nd Number or Ru	ural Route Number,	
Medical (29a. Certifier 1 ertifyi (Check only one) 2 Medica	ng Physician: To the best of I Examiner: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) , date and) and manner as d place, and due	s stated. e to the cause(s)	
M	29b. Signature and title of certifier C-Sci Cattra MD D0064539 29d. Date signed (Month, Day, Year) 1 18 08										
ate	S. Kanumuru MD, 73 31. Date filed (Month, Day, Year,	00 Van Dusen Rd	, Laure	I, Mary	/land 20707						
rar	JAN	2 4 2008	CN.	St. p	garde)						

Physician /Medical Examiner **Funeral** Director 10a. State 28a-f sh notifled Director Maryland the ral", or Items 23a or Examiner must be r Completed by Funeral death 11. Marital Status iled within 72 hours after Baltimore, Maryland 21215-0036 item 27 is marked other than "nature other traumatic event, the Medical 12 yrs. Be Pages 1 and 2 should be finent of Health and Mental Fint; If item 27 is marked of ဥ permit. Pages 1 Department of H Important: If ite any Injury or ot Physician /Medical Examiner Examine burial-tran P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE signed by the a d be detached for 9 Unknown Division or Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day KATHERINE S. TROTT A M 4120 22 2008 anuary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore 8. Date of Birth (Month, Day, Year) Aug. 1, 1916 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday, Months 1 ☐ M 2 🔀 F MARYLAND 91 215-09-2468 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore County Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 9911 Magledt Rd. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County N/A Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William John Schmidt Lilly Rose Wuntz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosann D. Scheufele(Niece) 9911 Magledt Rd. Baltimore. 21234 Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □Cremation 3 □Removal from State Dulaney Valley M.G. 1~26~2008 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PREU Monia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (*Month*, *Day*, *Year*) 29c. License number 29b. Signature and title of certifier D0065094 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed Dr Binh 9000 FRANKLIN Square DRIVE NGUYER Baltimore 31. Date filed (Month, Day, Year) 32. Re State 2008 JAN 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

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within 24 hours a

To the Funeral C

completely filled

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760, within 24 hours after deeth To the Funeral Director: A completely filled in by the f the Hospitai

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 5505 Hopkins Bayican Circle Baltimore, MD 21224)urso SAMUE 31. Dete filed (Month, Day, Year) State Registrar

> > **ORIGINAL**

29c. License number

D0047040

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Physician Louis E. Tabb 1507 2008 JUN497 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore of 5. Na. Hospital o 5. Social Security Numbrunk 6. Sex Balti more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Hours 1₩ 2□F unk Aug 25, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeiner. Insportant: It femz 73 a nz 28a-f show Important: It femz 73 a nz 28a-f show any Injury to other traumatic event, the Medical Examiner must be notified at 1▼ Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 USA 4669 Falls Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21☑ No black Specify þ 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sinai Hospital 2401 W. Belvedere Avenue Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Specify) in state 21. Signature of Funeral Service Ronald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 24a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardiothrombotic event Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examine attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 12 No 2 No 1□ Yes 1 ☐ Yes Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 | Inpatient 2 ER/Outpatient 1 ☐ Yes 3 DOA P After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c. Injury at Work? 27. Manner of Beath 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury М 1 ∏Yes 2 ∏No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title Dentifier 29d. Date signed (Month, Day, Year) D0057465

State

DHMH 17 Rev 1/2001

Attent Known As, Tabb, Louis

31. Date filed (Mo Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMPURSEMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** annay Wayson Dorothy /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arunde Baltimore Washington Medical Center Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🔀 F MAR 6 1932 218-28-7653 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 X No Director MD Edgewater Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21037 516 Highland Drive USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 5 1 ☐ Yes 2 X No Specify. Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 School Bus Driver Transportation irmit. Pages 1 and 2 should be filed wi epartment of Health and Mental Hygien portant: If item 27 is marked other the iy injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Far1 William 4 1 Sears Grace Hurlock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Kenneth Wayson - Husband 516 Highland Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or otl 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/24/2008 Baltimore, MD 21. Signature of uneral Service Licensee H. Williams 22. Name and Address of Eacility Cremation Society of Maryland, Inc. 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sapsis **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

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2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 24

2008

Maryland 21215-0036

30. Name and address of person who completed pause of death (Item 23a) Type, Print, Gen Burnie, Mary Land

32. Registrar's Signature

29c. License number D41365

29d. Date signed (Month, Day, Year)

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8(c	diam'r.		Registrar 1. Decedent's Name (First, Middle, Last)							2. Date of D	eath		3. Time	of Death
	Physicia	-	Carl E. Whisman, Sr.							Januar	y 20 ^{Da}	^y 2008 ^{Year}	12:58	В А М
Y	/Medic		4a. Facility Name (If not institution, give s	street and nu	mber)	-	4b. City, Town, or Location of Death				40	. County of Death		
			Laurel Regional Hospit				Laur			Prince Georges				
	Funeral Director		5. Social Security Number 6. Sex 218-30-8405	M 2□F	7. Age (In yrs	. last birthday) Yrs.	If Under Months		Under 24 Hours M	Hrs. 8. Date of B (Month, D June 28	Day, Year) Country)			e or Foreign
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	the N 28a-f	Director	10e. Street and Number	. 900			10f. Zip	Code			10g. Ci	tizen of What Cou	ntry?	<u>.</u>
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<u>ya</u>	ould b Ment arked atic e	T _O	Frank William Whisman							Harrison				
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertal Hyglene. Important; if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty) Donna Whisman- wife	pe. Print)			•			o <i>r Rural Route Num</i> el, Marylan			o Code)	
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	e Hospital or Attending Physician: 24 hours after death. 5 Funeral Director: After this certificately filled in by the funeral director,	edical (29a. Certifier (Check only one) Certifying Phy	iner: On the	basis of exami	nowledge, dea nation and/or i	th occurred nvestigatio	d at the time n, in my opir	, date and nion, death	place, and due to to occurred at the time	ne cause(ie, date a	(s) and manner as nd place, and due	stated. to the caus	se(s)
	To the Hosp within 24 ho To the Fune completely f	Med	29b. Signature and title of certifier		nner stated.	10:5%	29	c. License r	number		29d. D	ate signed (Month	, Day, Yea	r)
	F ≥ F ŏ		> Emarena	ئ _ە	Dair	udiac		00	65	7216	5	17N 2	0,2	003
•	10		30. Name and address of person who co					7.3X						
_	1		Michael Baako, MD, 730	00 Van I	Ousen Rd.	, Laurel		land 20	707					
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sig	nature	Sant	P						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wine Ruth Margaret 01 22 3:10 A M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake House Harwood Anne Arundel 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 ₩ F 07/13/1934 577-52-0892 73 MD **Director** Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show at a or 28a-f sho t be notified a 1 ☐ Yes 2X No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 711 Old Waugh Chapel Road 21113 U.S.A. death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. It is marked other than "natural", or ite nry or other traumatic event, the Medical Examinea. Iny or other traumatic event, the Medical Examinea. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify Specify 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Bookkeeper Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Clarabelle Carter William Paul Pratt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joanne E. King / daughter 711 Old Waugh Chapel Road, Odenton, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ं <u>न</u> 1 ABurial 2 ☐ Cremation 3 ☐Removal from State Department of Important; If any Injury or 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park : 01/25/2008 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, Mer357 Singleton Funeral & Cremation Services MD 21061 aveur 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20ms /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□Unknown 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s perform Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Chasasta K Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 🗌 Yes 2**2**No 1 Inpatient 2 ER/Outpatient 3 DOA Japaren 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours a To the Funeral I the

> State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

82

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	For State Registrar	State of Mar	yland /	Certificate				giene Reg. No. 2 (008	01563
	Physici /Medic		Decedent's Name (First, Middle, L. HILDA	ast)		WASS	SER		2. Date of Dea Month	Day	Year	3. Time of Death 0905 M
	Examir Funeral Director			of B9/1	In yrs. last b	Ba	Ihmor 1 Year If L	ation of Death Under 24 His ours Min.	8. Date of Birth (Month, Day 02/19	4c. County	N/A	lace (State or Foreign try) WV
	yland how at		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, To	wn or Location					10	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	MD BAL*	TIMORE	BALT	IMORE 10f. Zip	Code			10g. Citizen of	What Coun	1 ☐ Yes 2 🛣 No
	th with 23a or ust be	ral Di	8101 McDonogh Ro			10.1.2.10	2120	08			USA	
laser 3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes	2 X No Sp	nic Origin? (Spec lexican, Puerto F pecify:		Bla Specil	,.	etc. HITE
215-(hin 72 h e. an "natu Medica	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or 5+)	16	a. Decedent's Usua (Give kind of wor life. DO NOT us			og		WORLD	BOOK
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7€ Mary	nd 2 shoul Ith and M 27 Is marl traumati		19a. Informant's Name/Relationship MARIAN WASSER	, ,,		9b. Mailing Address 8101 McDo				-	, State, Zip 21208	*
of Mount	Pages 1 ar nent of Hea int: If item 2 iry or other		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 [of Disposition (Nan			ate	20c. Location		
Tim.	permit. Page Department of Important: If any Injury of once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice	ify)	BE	TH I SRAEL 22. Name an	<u>. CONG.</u>	01/22/ Facility SO	'2008)L LEVII	BALTIM	ORE,	MD
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B	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the yone cause on each line.	ne death. Do	not enter the mod	e of dying, su	ich as cardiac or	r respiratory an	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death)	b. Due to (or as a control of the desired of the de	Trac	+ 10A	hon					Iday
68760,	icate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	cDue to (or as a d						<i>O</i>		
P.O. Box 68	ath certif ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									ery Day Year
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Vita	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:			Othori	Place of Death	(Check only o	ne)		
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	With Void	Σ	29b. Signature and title of certifier	MARIAN	.10	290	License nun	mber		29d. Date sign	ed (Month,	Day, Year)
	15		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, Print)	EJ-	000	1 17	1 n	11	2008
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Sina	1	ospita	(Og	1 Bis	Khal	,
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08-00540 Iva Zacharias

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State legistrar			J		Certii	ficate of	Death			,	J	Reg. No	<u>.</u> 21	001	0156
Physician/ Medical Examine		1. Decedent's Name	e (First, Midd	lle,Last) Iva Za	char	ias						2. Date of I Month Januar	y 19, 20		r	3. Time of Death 0250 hrs
1	ľ	4a. Facility Name (i 9001 Chern		on, give	street and nu	imber)		4	b. City, To Laurel	wn, or	Location o	f Death		ľ	4c. County of Prince G		s
Funeral	1	5. Social Security N		6. Se	x	7. Age (I	n yrs. last	birthday)	If Under	_		r 24Hrs.	8. Date of	f Birth (MI	W/DD/YYYY	g. Birth Foreign	place (State or
Director		217-32-3		1	M 2 X F	9	2	Yrs.	Months	Day	s Hours	Min.	May	5, 1	915	Cou	ntry)Maryland
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5-0036 ed within 72 hour lygiene. other than "natu he.Medical Exar	1	Elementary/Seco	ondary (0-12)	College (1-4 or 5+)	_		ost of work	ing life	e. DO NOT	use retir	ed)				
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Division of Vital I To the Bospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be of		29a. Certifier 1 (Check only one)	Certifying I Medical Ex	Physici aminer	an: To the be On the basis	st of my k of examir	nowledge nation and	, death occur l/or investigat	red at the tion, in my	time, o opinio	date and pla n, death oc	ace, and	due to the at the time,	cause(s) date and	and manne place, and	r as state due to th	ed. e cause(s)
To ron	<u> </u>	29b. Signature and			and manner	stated.					se number						nth, Day, Year)
		14	70	() ()	n Mr.					O.C	.M.E.			J	anuary 20), 2008	8
		30. Name and addr Tasha Gree			completed cau Assistant N				Penn St	reet	, Baltimo	ore, MI	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** RHODA APPLEGATE 2008 5:50 PM Jan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis HealthCare -Talbot The Pines Easton 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Days Hours 1 M 2 X 91 SEPT 6,1916 **NEW JERSEY** 145-12-2094 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f shov Examiner must be notified at 1XYes 2 ☐ No Director TALBOT EASTON MD 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number **USA** 21601 610 DUTCHMANS LANE by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or tem any injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 0 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MYRTLE A. APPLEGATE LEROY APPLEGATE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 352 BOZMAN, MARYLAND 21612 RICHARD CLAYTON/PER. REP. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 1/9/2008 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 M. Ostrowsk. C.F.S.R Joseph Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** works Devereliza disease or condition resulting in death) /Medical Due lo (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the attending I for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be del þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No Yes 2 No 1 ☐ Yes certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Hospital: Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident a after death.

I Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours at To the Funeral E completely filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Bern &

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ıryıarıu			e of De		-	Reg. No.	2008	01566
		_	Decedent's Name (First, Middle, Last	it)						2. Date of De Month	ath Day	Year	3. Time of Death
. · · · ·	Physicia /Medic		James Elwoo	od Armstrong						January	03	2008	1:47 aM
)	Examine		4a. Facility Name (If not institution, give						n, or Location of Death 4c. County of Death				
			Holy Cross I 5. Social Security Number 6. S		(In vrs. la	st birthday)		Silver 1 Year If	Spring Under 24 Hrs.	8. Date of Bir	th	Montgomery 9. Birthplace (State or Foreign Country)	
	Funeral Director			M 2□F	78	Yrs.	Months	Days F	lours Min.	(Month, Da			intry) aryland
	ъ		Usual Residence of Decedent										
	show dat	_	10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma	Director		gomery			10f. Zip		er Spring		10a Citiz	en of What Cou	
	a or i	흐	10e. Street and Number				101. Zip		0904		rog. omz	U.S.	·
	ns 23	Funeral	2205 Solmar Drive	12. Was Decedent B	Ever in U.S.	. 13. y	Vas Dece		anic Origin? (Spo Mexican, Puerto	ecify Yes or No	p- 1-	4. Race - Amer	ican Indian,
٥	after or iter		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: (^{lo} Korea	n i	r yes, spe 1 □ Yes		Mexican, Pueπo Specify:	Hican, etc.)		Black, White Specify:	, etc.
2-003p	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced		Conflic							Can	ucasian
ភ្ន	"natu	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced (Give life, L	tent's Usu kind of wo DO NOT u	al Occupatio rk done duri se retired)	in ing most of work	ing	16b. Kin	d of Business/I	ndustry
V	withir iene. than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			Attorne				Pate	nts
0	other ent, t	Be C	17. Father's Name (First, Middle, Last,					18	3. Mother's Name	e (First, Middle	, Maiden S	Surname)	
ylan	uld be Menta Irked Itic ev	ToE	James Elwood A	rmstrong, II						en Ameli			
Mar	2 sho and i is ma		19a. Informant's Name/Relationship (Type. Print)			•	•	l Number or Run				(ip Code)
e o`	l and lealth em 27 ther to	-	Susan E. Armstrong 20a. Method of Disposition	- Wife	20h Pla				, Silver	Spring,		nd 20904 cation - City or	Town, State
E E	nt of H		1 ☐ Burial 2 ☑ Cremation 3 ☐			ace of Dispo metery, cren			1			·	
attll	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If tem 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Ì	4 ☐ Donation 5 ☐ Other (Specification 21, Signature of Funeral Service Lices		Fort		2. Name ar	nd Address o	of Facility	5/2008		twood, Ma	aryrand
ñ	Dep Jub any any) alog	Damel	90	H:	ines-R 1800 N	inaldi ew Hamp	Funeral H shire Ave	lome, Inc nue, Sil	ver Sp	ring, Ma	ryland 20904
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused one cause on each lir	the death.	Do not ent	er the mod	de of dying,	such as cardiac	or respiratory a	ırrest,		Approximate Interval Between
jā.	Physician		Immediate Cause (Final disease or condition	a Acute G.								9	Onset and Death
6.	/Medical Examiner		resulting in death) Due to (or as a consequence of):										
	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Hypertension Due to (or as a consequence of):										
)	uted insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events										
-	execu an and rial-tra	Exa	resulting in death) Last	Due to (or as	a conseque	ence of):							
08/00	eath certificate be executed attending physician and for use as the burial-transit	edical		_ d			_						
_	certifica nding ph use as t	Med	IF FEMALE:	OGo If you autooma	nf nroanom	101/							
X R R	death c e attenced for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	⊒Ectopic p ⊒ Other <i>(s</i>				2	3d. Date of del	Day Year
o.	000	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□Unknown	time or de		2011101 (0						
7	law requires that the dias been signed by the 2 should be detached	by Pr	Part II. Other significant conditions	contributing to death be	ut not resul	ting in the u	nderlying	cause given	in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ī	equire en sig ould b	ed b	Atrial Fibrillation	1	-					1 🗆	Yes 2]No 3∏Pr	obably 4 🖫 Unknown
Vital Hecords,	in so or	Completed	Insulin Dependant I	Diabetic						24a. Was	psy	24b. Were au	utopsy findings available completion of cause of
I =	afe ⊤	Com	CAD							perf 1⊟ Yes	ormed? 2 ☑ No	death? 1 ☐ Yes	2 □ No
V [2	slcian: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner?	Hospital:					6. Place of Deal	,			
ō	Phys r this ral dir	٦.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	iry	P/Outpatier 28b. Time o		28c. Injury a Work?	4 ☐ Nursing Hot	ome 5 L Res 28d. Describe			cify)
0	nding th. : Afte e fune	tion	1 Natural 5 Pending 2 Accident Investigatio	(<i>Month, Da</i> n	y Year)	Injury	М		s 2 □No				
Division	After er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At hor	ne, farm, str	reet, factor	y, office		28f. Location City or To	(Street and	d Number or Ru	ural Route Number,
5	ital or rs afte ral Dir led in	Cert		Na.					4	<u> </u>			
	Hosp 24 hou Funel tely fil	Medical	29a. Certifier 1 ★ Certifying Pl (Check only one) 2 ★ Medical Exa	nysician: To the best miner: On the basis o	f examinati	vledge, deat ion and/or in	th occurred rvestigatio	d at the time, n, in my opir	, date and place nion, death occu	, and due to the rred at the time	e cause(s) e, date and	and manner as place, and due	s stated. e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to make the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director dir	Med	29b. Signature and title of gentifier	and manner sta	aleu.		29	c. License n	umber		29d. Dat	e signed (Mont	th, Day, Year)
			· Klina	9-	\bigcirc				D59837		Jan	uary 3,	2008
,	12		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)						
			Khanh Nguyen, M.D.,	1500 Famort	Clan D	and C	. 1	Carina	MD 2091	0			
			31. Date filed (Month, Day, Year)	32. gistr			liver	spring,	FID 2091	.0			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 05:00A[™] LAYTON SOUTHERLAND ALLEN 1/7/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HERON POINT CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1**X** M 2□ F Director 221-18-6940 88 02/08/1919 DE Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f show notified at 1 ☐¥es 2 ☐ No Director MD KENT CHESTERTOWN 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? pe l "natural", or items 23a 227 HERON POINT 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 42-46 Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21🙀 No Specify. Specify: WHITE Completed by 3 Widowed 4 Divorced item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 INSURANCE BROKER INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES LAYTON ALLEN ELIZABETH SOUTHERLAND ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE ALLEN/WIFE 227 HERON POINT CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department or Important: If any injury or once. CHESAPEAKE CREMATION 1/8/08 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 tella 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART **Physician** ONGESTIVE year /Medical Due to (or as a consequence of): Examiner URUNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BRUSIS 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page certificate Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation thours a er death. the 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number D004(587 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 Z

State Registrar

+

DHMH 17 Rev 1/2001

ORIGINAL

122 Speer Rd. Cheskertown, MD 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Helen A Noble, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 2008 **Physician** 3 3:15 Рм Richard Arnold */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1**X** M 2□ F 60 Yrs 215-48-5222 Director 10/7/1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Carroll New Windsor MD r 28a-f sh notified 1 ☐Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 must be n United States 4042 Franklinville Rd. 21776 death \ Funeral item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner man 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) tal Hygiene. College (1-4or 5+) Superintendant Miller, Long, Arnold Construction 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in Nannie May Warfield and Mental Roger G. Arnold, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4042 Franklinville Rd. New Windsor, MD 21776 item 27 is Lynda Arnold(wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Cepartment of H In portant: If ite any injury or of once, 1 Burial 2 □ Cremation 3 □ Removal from State Taylorsville, MD Jan 7, 2008 4 □ Donation 5 □ Other (Specify) Tavlorsville Cem 22. Name and Address of Facility Burrier-Oueen Funeral Home and Crematory, PA 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Euner-Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage To nonsmall-cell /Medical Due to for as a consequence of): Examiner Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ed by the a detached f Type 2 No 9 Unknown been signed by should be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Trobably 4 □Unknown 1 ☐ Yes 2 ☐ No Ausions 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has all director, page 2 autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No P Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: illed in by the funer (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie owe kan 10066295 2008 01 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) memorial Onatowokan THY SICIAN MANAGEMENT Olytun lolu LID west minster MD 2115) 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

JAN 0 7 2008

			For State	State of Ma	aryland /		irtment of		ınd Me	-	2	008	0156	, 0
	- A		Registrar 1. Decedent's Name (First, Middle, Last)			061	incate of	Death		2. Date of De	Reg. No	000	3. Time of Death	1
	Physici		Jane Meredith H							Month	V 08	2008	21451	M
	/Medic Examin	125	4a. Facility Name (If not institution, give s				4b. City, Town,	or Location o				inty of Death		_
			Washington Cour	ity Hospi	tal		Ha	gersto	wn		Was	shingt	on County	
	Funeral		5. Social Security Number 6. Sex	7. Ago M 2 □X F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Bir (Month, Da	th <i>y, Year)</i>	9. Birth	place <i>(State or Fore</i> <i>intry)</i>	ign
€-	Director	8	220-16-3039 Usual Residence of Decedent	41	86	113.				April	21 192	21[]	Maryland	_
	/land		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Lim	its
	Man a-f sh ified	ctor	Maryland Washir	igton		Hage	rstown						1 □ Yes X□	40
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
	ath wi		1175 Profession					21742				U.S		_
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:			Vas Decedento fYes, specify Cu I□Yes 2ሺNN		gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)		Race - Amer Black, White ecify: W		
215-0036	רסטו 72 ה "naturai edicai בי	Completed	15. Decedent's Edu (Specify only highest grade	cation	1	(Give	lent's Usual Occ kind of work don OO NOT use reti	e during most	t of workin	g	16b. Kind o	of Business/I	ndustry	
7	filed within 72 Hygiene. kther than "nai kther the Medic:	dwo	Elementary/Secondary (0-12)	College (1-4or 5	i+)		Ношеша				Por	conal	Residenc	_
2	illed Hygin Hygin Her Hent, t	Be C	17. Father's Name (First, Middle, Last)				пошеща		r's Name	(First, Middle	, Maiden Sur		Vestrenc	=
<u> a</u>		To B	James M. Schust	er					Made	line D	ryer S	chust	er	
Maryland	s 1 and 2 should I f Health and Men item 27 is marker other traumatic		19a. Informant's Name/Relationship (Ty	pe. Print)		19b. Mailir	g Address (Stre	et and Numbe	er or Rural	Route Numb	er, City or To	wn, State, Z	ip Code)	
	and lealth m 27		J. Timothy Bussar	d - son	OOh Bloo	01d	e Water	ford Ro	oad H	agerst	own Ma	ryland	d 21742	
Baltimore,	0 O		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R	lemoval from State			sition (Name of natory or other p	1						
	permit. Pag Department Important: any Injury conce.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Rest		n Cemeto . Name and Ado			12 08			n Marylan	1
ga	permit. Pag Department Important: i any injury o	10	21. Signatura di Funeral Service Licensi	7/104					DOU				eral Home	<i>i</i> . ว
			23a. Part1. Enter the disease, of complishock, or hear failure. List only or	ications that caused	I the death. [Do not ent	or the mode of d	ying, such as	cardiac or	respiratory a	erstow rrest,	n Mar	vland 2174 Approximate Interval Between	12
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	/Medical		disease or condition resulting in death)	Due to (or as					0				94	_
	Examiner		Sequentially list conditions,	o										
	pa tig	iner	by if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
	recute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequen	ice of):						-		
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O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □								23d.	Date of deli Month	very Day Year	
٦.	that the ed by detac		Part II. Other significant conditions con	ntributing to death b	ut not resultir	ng in the u	nderlying cause	given in Part I.		23e. Did	tobacco use	contribute to	the cause of death	,
Records,	w requires that been signed b should be deta	d by	neet full	profite	her	and it	-jany			1 🗆	Yes 2□N	lo 3□Pro	obably 4 🖳 🖽 nkho	wn
င္ပ	s beer	lete	Dehrenetian &	inan	Anten	_ (min	^		24a. Was		4b. Were au	topsy findings availa	ıble
Ä	The law cate has l	Completed	aterentity							auto perfe 1□ Yes	ormed?	prior to death? 1 ☐ Yes	completion of cause 2 ☐ No	of
VIta	ician: Th certificate ector, paç	Be C	25. Was case referred to medical examiner?					26. Place	of Death	(Check only				
	hysic his ce	To E	1 A Yes 2 No	lospital: 1 Hnpatie			1 3 DOA				idence 6 🗆		cify)	
ב	ing P		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		3b. Time o Injury	l v			8d. Describe	how injury oc	ccurred		
<u>s</u>	ttend leath.	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	uni - At home	form etr		Yes 2		8f Location /	(Street and N	umber or Ru	ıral Route Number,	
Division or	after of Direction by	Certification:	4 Homicide determined	building, et	c. (Specify)	s, Idilli, 3ti	eer, ractory, one	C	-	City or To	wn, State)	arriber or the	nai i louic i lumber,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physics	sician: To the best	of my knowle	edge, deat	n occurred at the	time, date an	nd place, a	ınd due to the	e cause(s) and	d manner as	stated.	
	n 24 h	Medical	(Check only 2 Medical Exami one)	iner: On the basis o and manner sta		n and/or in	vestigation, in m	y opinion, dea	ath occurre	ed at the time	, date and pla	ace, and due	to the cause(s)	
	To the To the Com	Ň	29b. Signature and title of certifier					nse number				-	h, Day, Year)	
)			-at mo				D .	8019			~~~	9,2	<u>8</u>	
51	1-5		30. Name and address of person who co	e-ex me	3	40 /	Print)	7 1	1461	ERJA	ow~,	No.	21240	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 1 **Physician** 2008 15:41 M John W. Bradford 9 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/4/1929 7729 Downs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F 214-28-1431 78 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ahow Director 1 ☐ Yes 2 XNo MD Worcester Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7729 Downs Rd. 21841 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 √Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Menta! Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Norman Bradford Maude Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trait 7729 Downs Rd., Newark, MD 21841 Carrie Bradford / wife 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 1/14/2008 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home veelt) 108 William St., Berlin, MD 21811 239 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOCARDIAL EN MINS INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed?

1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25-Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 106241 C. Adjust, Mid, 1-10-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

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JAN 1 0 2008

DOROTHY 31. Date filed (Month, Day, Year)

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DOD: 1998

DOB. 12/4/29

HOLZWORTH, M. D

32. Registrar's Signature

Kilasur

203 SMOW ST. SNOW HILL, IND. 21863

Physic /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

For State		State c	ות iviarylar		artment of Health a ctificate of Death	and Mental		3	
Registrar Decedent's Na	me /Firet Midall	e. Last)		cer	imoaie di Dealil	2. Date of	Reg. No.	2008	3. Time di-Death
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207-03-8		1 X M 2□F	90	Yrs.	Months Days Hours	oct	21, Year) 21, 191	17	PA
Jsual Residence 0a. State	of Decedent 10b. County		10c Ci	ity, Town or Loc	cation				10d. Inside City Limits
			133.0						1 XYes 2 □ No
MD 0e, Street and N	TALB	OUT	1	EA:	STON 10f. Zip Code		10g. Citiz	zen of What Co	untry?
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20a. Method of D		LE/ DAUGH	20b.	Place of Dispos	HUGHLETT ST.,	EASTON,		601 cation - City or	Town, State
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Medical Certific

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

6

JOHN BOTSIS M.D.

29b. Signature and title of certifier

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST EASTON, MD 21601 9 2008

and manner stated.

31. Date filed (Month, Day, Year, JAN 0

State

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D0059487

29d. Date signed (Month, Day, Year)

		1	For	State	of Marylar	nd / Depa	artmen	t of H	ealth and	Mental Hy	giene		
•	Ť		State Registrar			Cei	tificat	e of [Death		Reg. No.	2008	01572
ķ		576	1. Decedent's Name (First, Middle,	Last)						2. Date of De	eath Day	Year	3. Time of Beath
	Physicia /Medic		James Robert	Blaschke						January	06	2008	1952 ^M
Y.	Examin	4	4a. Facility Name (If not institution,	give street and no	umber)		4b. City,	Town, or	Location of Dear	th	4c.	County of Death	
		4	Holy Cross Ho				1611		lver Spri			Montg	
	Funeral		5. Social Security Number	6. Sex 1⊠M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Cour	
Ŀ	Director		395-42-0323 Usual Residence of Decedent		63	110.				Septembe	er 28,	1944 Wis	consin
	land bw		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	Mary f sho	Ö	Maryland Monts	gomery				Si 1	ver Spring	7			1 ☐ Yes 2X No
	the 728a	Director	10e. Street and Number	30 mer y			10f. Zip		ver oprin	,	10g. Citi	zen of What Cour	itry?
	3a o	0	12911 Tourmalin	ne Terrace					20904			U.S.	Α.
	deatl	Funeral	11. Marital Status		cedent Ever in U	I.S. 13.	Was Dece	dent of Hi		Specify Yes or Norto Rican, etc.))-	14. Race - Americ Black, White,	
9	after or ite	Œ	1 ☐ Never Married 2 ☑ Marrie	d 1 ∑ Yes	2 □ No		1 □ Yes		Specify:	no moun, cto.)		Specify:	610.
15-0036	ours ral", Exa	d b	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates: Unkno	wn	100	222110	орсону.			ur-c-sc-	White
2	72 h 'natu dical	Completed	15. Decedent's (Specify only highest	Education grade completed	0	16a. Deced	dent's Usu kind of wo	al Occupa rk done o	ation Juring most of wo)	orking	16b. Ki 	nd of Business/In	dustry
2	vithin ne. han '	ш	Elementary/Secondary (0-12)	College	(1-4or 5+)	1						Commo	mai al
7	be filed within 72 hours after death with the Maryland ttal Hyglene. did other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	රි	12 17. Father's Name (<i>First, Middle, L</i>	aet)		Ins	urance	Appr		me (First, Middle	. Maiden	Comme Surname)	rciai
anc	ntal H ed ot	Be	Robert Blas							Marian Gie		ourname)	
Maryland 21	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show armatic event, the Medical Examiner must be notified at	ပ	19a. Informant's Name/Relationshi			19b. Mailir	na Address	(Street a				r Town, State, Zip	Code)
Σ	id 2 s Ith an 27 Is trau		Joanne Blaschke					•				ing, Maryl	
อ์	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		20a. Method of Disposition	, WIIC	20b.	Place of Dispo cemetery, crei				Date	_	cation - City or To	
9	6 O		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	ite of He			! .	11/2008	Silv	er Spring,	Marvland
Baltimore,	permit. Page Department (Important; If any injury or once,		21. Signature of Funeral Service L		-	22	2. Name ar	nd Addres	s of Facility		-	or pprans,	11017 2011
ñ	Dep Jany any any any	2 3	1 (Imanda	Ludi	MXIII	H 1	ines-R 1800 N	inald ew Ha	i Funeral mpshire A	Home, Inc venue, Sil	ver S	pring, Mar	yland 20904
			23a. Part1. Enter the disease, or can shock, or heart failure. List of	complications that	caused the dea	th. Do not ent	er the mod	le of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
	Physician	R Y	Immediate Cause (Final disease or condition		ardio Res	niratory	Arres	t					Onset and Death Terminal
	/Medical		resulting in death)	a.	o (or as a conse								
lo.	Examiner		Sequentially list conditions		b. Dilated Cardiomyo athy Due to or as a consequence of: 7 years								
	D #	Examiner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a conse	uence of	uence of):						
	ecute and -trans	Kam	that initiated events resulting in death) Last	c	o (or as a conse	ruance of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			Due to	5 (01 d3 d c011sc	4401100 017							
8/	physi the I	dical	·	d									
×	death certific attending p	Physician/Me	IF FEMALE:	23c. If yes, o	utcome pf pregr	ancy						23d. Date of deliv	erv
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		birth 2 Fet gnant at time of		∃Ectopic p ∃ Other <i>(s</i> i					Month	Day Year
o.	uires that the de signed by the a Id be detached f	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	nown								
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ğ	quire in sig uld be	ed by	Obesity				_			1 🗆	Yes 2	□ No 3□ Pro	bably 4⊠Unknown
ပ္တ	aw requir s been s 2 should	olete	Hypertension							24a. Wa		24b. Were auto	opsy findings available empletion of cause of
Vital Records,	Physician: The lav this certificate has ral director, page 2	Completed								per 1□ Yes	opsy ormed? 2 🔀 No	death?	2□ No
<u>ta</u>		Be C	25. Was case referred to medical examiner?						26. Place of De	eath (Check only			
	nysic alis ce direc	To E	1 Yes 2⊠ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3⊠ D	OA Othe	er: 4 ☐ Nursing	Home 5 ☐ Res	sidence	6 ∐Other (Speci	fy)
Division or	ng Pl fter th		27. Manner of Death 1 X Natural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time o Injury	f :	28c. Injur Worl	y at k?	28d. Describe	how inju	ry occurred	
200	or Attending Proter death. Nirector; After to by the funera	atic	2 Accident investiga	ation			М		Yes 2 No				
Ž	after de Direct	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and IZOE, Flat	ce of injury - At I Iding, etc. (Spec	nome, farm, sti <i>ify)</i>	reet, factor	y, office			(Street ar own, State	nd Number or Run e)	al Houte Number,
	pital urs a eral [29a. Certifier 1 X Certifying	Physician: To the	ha hast of my kn	owledge deat	h occurred	at the tir	ne date and nia	ce and due to the	e cause(s) and manner as	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical E	xaminer: On the	basis of examinanner stated.	ation and/or in	vestigation	n, in my o	pinion, death oc	curred at the time	e, date an	d place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29	c. License	e number		29d. Da	te signed (Month,	Day, Year)
	10		Warren !	h. Don	walk	cknu	(8)	חת	012121			January 7,	2008
7	Ψ		30. Name and address of person v	vho completed ca	se of death (Ite	m 23a) (Type,	Print)						
_			George Sengsta				e, Sil	ver S	pring, Ma	ryland 209	06		
	Sta		31. Date filed (Month, Day, Year)	32.	Pegistrar's Sign	ature	-	•					
	Registi	ar	PO MAL	2008	20,000	IF A	TO THE						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 5 2008 ear 7:35 P Simon BLACK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda 4925 Battery Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 325-28-4932 1 M 2 □ F Wisconsin 9, Director Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miles he marifical at 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Bethesda Maryland 1 ☐ Yes 2 X No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20814 4925 Battery Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. white 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 ģ Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colleger 1-4or 5+) Biochemist N.I.H. 17. Father's Name (First, Middle, Last)
Rennard Black 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Holland Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rov Black / son 8062 30th Ave., NE, Seattle, WA 98115 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01/07/08 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Hypotension **Physician** disease or condition resulting in death) /Medical Due to (or as a consequen 3 1f): Examiner Congestive Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner als certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Plewal 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) **JAN 0 9 2008**

8120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MID

w. Hwang

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** DAVID OAKLEY VANDERPOEL BARROLL 1/1/2008 02:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER MANOR CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F Director 220-32-9461 5/3/1932 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show MD **KENT** CHESTERTOWN 1 XYes 2 No Director 10e. Street and Number 10f Zin Code 10g Citizen of What Country? items 23a or 2 iner must be n 202 DAVID DR. 21620 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 TYes 2 No If Yes, Give Year or Dates: **KOREA** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify Specify: WHITE Completed by 3 Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 REAL ESTATE BROKER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORRIS KEENE BARROLL MARGARET NEWCOMER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY CUTTER/DAUGHTER 572 TOILSONE HILL RD. FAIRFIELD, CT 06825 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) PAULS CEMETERY CHESTERTOWN, MD 1/4/2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kuck & FELLOWS HELFENBEIN & NEWNAM FUNERAL 130 SPEER RD. CHESTERTOWN, MD 21620 HOME, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocaneial hr /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE JSe 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 2 No 3 Probably 4 Unknown estension 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s certificate has autopsy performed? (es 2 No 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident after death To the Hosp...

To the Funeral Director:
"**elv filled in by th 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

10

6602 ChurchHill Rd. Chestroun, MD

MO

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN 0 4 2008

MD

Frederick Delbus

31. Date filed (Month, Day, Year)

VOID

CERTIFICATE

2008-01575

SEE

CERTIFICATE #

2008 - 02848

deceased - Dustin Elliott Bruch

		ı	For State	State of Maryl	-			nd Me	ntal Hyg	iene	UUU	01576
			1 - State Registrar		Ce	rtificate	of Death			g. No.	, 0 0 0	01010
	Physicia	an	Decedent's Name (First, Middle, L					2.	Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Leonard Robert 4a. Facility Name (If not institution, gi			4b. City. To	own, or Location of	Death			08 ounty of Death	
	Examin	er	17620 Virginia				gerstown			W	shingt	on
	Funeral	9		Sex 7. Age (In	yrs. last birthday)	If Under 1	Year If Under 2-	4 Hrs. 8. Min.	Date of Birth (Month, Day,			place (State or Foreign intry)
	Director		366-42-5608	¹\	Yrs.		,	N	March 9	194	1 Mic	higan
	and DW		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation						10d. Inside City Limits
	Mary Ff eh	tor	Maryland Washin	gton	Наде	rstown						1 ☐ Yes 2√2 No
	th the	Directo	10e. Street and Number	800		10f. Zip C	Code		1	0g. Citize	n of What Cou	intry?
	deeth with the Maryland ms 23a or 28a-f ehow r must be notified at	rai	17620 Virginia A				21740			US		
	er der Itame	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deceder If Yes, specifi	nt of Hispanic Origi y Cuban, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)	14	 Race - Amer Black, White 	
36	hours after tural', or ita	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1	8-196/	1 🗆 Yes 2	No Specify:			5	Specify: W	hite
		ted	15. Decedent's I	Education	16a, Dece	dent's Usual	Occupation done during most	of working	1	16b. Kind	d of Business/I	ndustry
21	within 72 ane. than "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)					
2	iled w tygier her th		12 17. Father's Name (First, Middle, Las	1	Film	Prep I	Departmen		First, Middle, I		inting	
Maryland	d be fi) Be	Leonard Crapoff	,					odhams		arriarrio,	
Ž	2 should be and Menta le marked aumatic av	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (June Street and Number				Town, State, Z	ip Code)
	O. (0 = at		Margaret Crapoff	- wife	176	520 Vi	rginia Av	enue,	Hager	stow	m. Md.	21740
e e	es 1 and 2 of Health of Item 27 I		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3		b. Place of Disponentery, cre	osition (Name matory or oth	e of ner place)	Date	θ	20c. Loca	ation - City or	Town, State
Ě	Pages ment of tant: If It lury or o		4 □Donation 5 □ Other (Spec	eify)			ematory 1		08	Hage	rstown	, Maryland
Ball	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Lice	pay			Address of Facility	1.17			ral Ho	
	40240										, Mary	land 21740 Approximate
١,	Dhysisian		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final		1	1	* *		,			Interval Between Onset and Death
<i>)</i> -	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor		rtery	Dizeaso	2				
H	Examiner		Sequentially list conditions,	4	rperter	Noizn						
	D #	iner	r any, leading to immediate cause. Enter Underlying	Due to (ur as a cur	nce of):	V.						
d	be executed iclen and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cor	Did De	tes						
760,	ate be executed lysiclen and he burial-transit	cai E										
	ifficate g phys as the			d		Santa Santa						
. Box	Attending Physician: The law requires thet the death certificat croad. actorially. actorially. by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐		☐Ectopic pred	onancy			23	3d. Date of deli	,
E	e deal	sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (spec					Month	Day Year
0.	thet the de led by the a detached f	Phy	Part II. Other significant conditions	contributing to death but no	t resulting in the I	ınderiving çaı	use given in Part I		23e, Did tol	bacco us	e contribute to	the cause of death?
Records,	w requires the been signed I should be det			ipidemia			200 g. (01. 11. 1 a. ()			es 2 🗷		obably 4 Unknown
Sor	w requ	Completed	1197						24a. Was a	n	24b. Were au	topsy findings available
Re	The law te has age 2	omp						_	autops perform	med?_	death?	ompletion of cause of
Vital	iician: Th certificate rector, paç	BeC	25. Was case referred to medical				26. Place	of Death (0	Check only on			
<u>></u>	Physic this ce al direc	10	examiner? 1 Yes 2 No		2 ER/Outpatie						Other (Spec	eify)
Division of	ding P	inol	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	of 280	c. Injury at Work? 1 \(Yes 2 \(\) N	1	d. Describe h	ow injury	occurred	
Si	after death after death Director:	ficat	2 Accident investigate 3 Suicide 6 Could not	be One Diago of Injury	At home, farm, st						Number or Ru	ral Route Number,
<u>S</u>	al or a after a blood of the bl	Certification:	4 Homicide determine	building, etc. (S)	pecify)	,			City or Towi	n, State)		
	To the Hospital or Attending Physician: The i within Z4 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best of my aminer: On the basis of examiner	knowledge, dea mination and/or in	th occurred at	t the time, date and in my opinion, death	l place, and h occurred	d due to the c at the time, d	ause(s) a ate and p	and manner as place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier.	and manner stated.		29c.	License number		2	9d. Date	signed (Mont)	n, Day, Year)
	⊢ ≶ ⊢ ŏ		Sang 1. (Ille.			D005728	35			1/10/	2008
		Ų	30. Name and address of person wh	o completed cause of death	(Item 23a) (Type		(700.57					
3+	4-7		a.J. Koilpil	lai, 24 N	· Walnu	t2 t.	#102	Hage	vstown	M	D, 217	40
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	Acort.	,	J		,		

DHMH 17 Rev 1/2001

	Please	Type or Prin	t in Blac	k In	delible Ink	. Ensure Al	II Copies	Are Le	egib	le.	
For		State of Ma	ryland / I	Depa	artment of H	Health and M	lental Hy	giene			
State Registrar				Cei	rtificate of	Death		Reg. Non	0.0	0 0	11577
1. Decedent's Name	e (First, Middle, La	ast)	-				2. Date of De		UU	0 3.	Time of Death
HAROLD	PAUL	CHRISTMAN					JANUAR	Y 8	200	ear 8	2:30 P M
4a. Facility Name (II	f not institution, gi	ve street and number)			4b. City, Town, o	r Location of Death		4c. Co	unty of	Death	
UNIVERSI	TY OF MA	RYLAND		BALTIMORE CITY							
5. Social Security N		Sex 7. Age 1 M 2 □ F	(In yrs. last bi	Months Days Hours Min. (Month, Day, Year) C						Country)	YORK
Usual Residence of	0.5			110113				,			
10a. State	10b. County		10c. City, Tov	n or Lo	cation					Inside City Limits	
MARYLAND	WASHI	NGTON			HAGEI	RSTOWN					1 □Yes 2 No
10e. Street and Nur	mber			10f. Zip Code				10g. Citizen of What Country?			
14058 SW	EET VALE	DRIVE			21742				U.S	S.A.	
11. Marital Status		12. Was Decedent B		S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am Black, Wh						 American Ir White, etc. 	ndian,
1 Never Marri	ied 2☐ Married	1 ☑ Yes 2 ☐ N If Yes, Give	∘ 1942–)42- 1 □ Yes 2 ☑ No Specify:					pecify:	vvinto, oto:	
3 🙀 Widowed	4 Divorced	Year or Dates:	1946	46					secity.	WHI	ITE
(Spec	15. Decedent's E	Education rade completed)	168	16a. Decedent's Usual Occupation (Give kind of work done during most of working			king	16b. Kind	of Busi	iness/Industr	ry
Elementary/Seco	ondary (0-12)	College (1-4or 5		life. DO NOT use retired)					OD A	DITTO	CHIDDLY CO
		5+		NATIONAL SALES MANAGER PHOTOGRAPH 18. Mother's Name (First, Middle, Maiden Surname)						SUPPLI CU	
17. Father's Name						ANN WATSO	,	, Maiden Si	irname,)	
19a. Informant's Na			10	h Mailie	ag Addroop (Stroot	and Number or Rur		or City or T	owa C	toto Zin Cor	do
SUSAN D.		, ,			CAROLLE S						NIA 17225
		OGILLER			osition (Name of		Date			ity or Town,	
		Removal from State	cemete	ery, crei	matory or other pla RG CREMAT	ce))/2008				MARYLAND
21. Signature of Fy	heral Service Lice	/ //	M. Dea		2. Name and Addre	•	7606 03 Boonsbo				re 21713
23a. Part1. Enter t	he disease, or cor	mplications that caused y one cause on each lin	the death. Do	not ent	ter the mode of dyi	ng, such as cardiac			ur y	Ap	proximate erval Between
Immediate Cause ((Final	_a.	Sep	si	5					2	set and Death
resulting in death)		Due to (or as	a consequence	of):	\						. /
Sequentially list co	nditions	ь. До	acter	10	mia					6	days
Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying	Due to (or as	a consequence	of):							1
Cause (Disease or that initiated events	injury	c									
resulting in death) I	Lasi	Due to (or as	a consequence	of):							
	-										

Physician /Medical Examiner

attending physician and for use as the bunal-trar

neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buna

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

sepsis	Onset and Death 24 hours
Due to (or as a consequence of):	
bactevema.	6 day
Due to (or as a consequence of):	
0.	<u> </u>
Due to (or as a consequence of):	
1	

IF FEMALE:

1 - For State Registrar

Director

Funeral

Completed by

Be To

Physician

/Medical

Examiner

Funeral Director

> 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9☐Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes

24a. Was an autopsy 1☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 Inpatient 3□ DOA 1 Yes 2 No 2 ER/Outpatient

28a. Date of Injury (Month, Day Year)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who sampleted cause of death (Item 23a) (Type, Print)

21201 22 South Greene Street, Baltimore, Maryland M.D. Stephanie Montgomery,

02H-10-1 State Registrar

24 hours after death Funeral Director:

completely

To the

31. Date filed (Month, Day, Year) JAN 1 0 2008

32. Registrar's Signature

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month HELEN CZYR-JONES 2008 5:45 Jan 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare -The Pines Easton Talbot 8. Date of Birth (Month, Day, **JUNE 1** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2**K** F Hours 1924 83 Director CONNECTICUT 046-18-5880 Usual Residence of Decedent 10c. City, Town or Location a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ¥Yes 2 □ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 MECKLENBURG AVE., APT 219 21601 USA by Funeral 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Helen Czyr-Jones Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 【No Specify: Specify: 3 □ Widowed 4 □ Divorced WHITE "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT VOCATIONAL SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK CZYR ۴ VIOLET SZALL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY L. NOCK/DAUGHTER 103 LAWYERS ROW, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any injury or ott 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 1/7/2008 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licenses OSTROUSK m. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner obacco abuse rears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Division or Vital Records, P.O. Box 68760, or Attending Physician: Director: After that in by the funeral within 24 hours a

To the Funeral I

completely filled Hospital

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Pri

State Registrar

Medical

 m_{U} 610

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner πust be notified at

traumatic event, the

other

injury or Department or Important: If any injury or Director

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Completed

Be

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Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Saltimore, Maryland 21215-0036

and burial-tra physician the as for use detached signed by t I be detach this

law requires that the death certificate be executed funeral director, or Attending 24 hours after death e Funeral Director; filled in by Hospital completely within 2

Division or Vital Records, P.O. Box 68760

	d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 N No 9 □ Unknown	23c. If yes, outcome pf pregr 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions		sulting in the underlying	g cause given in Part I.	1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed′	
25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣No	Hospital: 1 ☐ Inpatient 2 ☐	□ER/Outpatient 3□	Othor	eath (Check only one) Home 5 Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, fact	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	nowledge, death occurr nation and/or investigati	ed at the time, date and plaction, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29h Signature and title of certifier		2	29c. License number	29d. I	Date signed (Month, Day, Year)

Fernwood Rd, Bethesda, Md 20817

State Registrar

DHMH 17 Rev 1/2001

he and add

ress of person who completed cause of death (Item 23a) (Type, Print)

0 9 2008

10215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar	•	artment of F <i>rtificate of I</i>		-		
_			Registrar		Ce	runcate or i	Dealli	2. Date of De	Reg. No	01580
т	Physicia	ın	1. Decedent's Name (First, Middle,					Month	Day Voor	
1	/Medic	al	Constance R. Cica			T		January	4, 2008	9:28 a M
	Examin	er	4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	ath
1		21	Laurel Regional	Hospital	(la ta ad himbhala si	Laure If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Prince	George's
D.	Funeral		5. Social Security Number 6	. Sex 7. Age ('In yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	rthplace (State or Foreign fountry)
ps.	Director		579-12-9572 Usual Residence of Decedent		86			Oct. 12	, 1921 Was	hington, DC
	and	ŀ	10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	//anyl	ö								1 ☐ Yes 2 🔼 No
	the last	Director	Maryland 10e. Street and Number	Montgomery	Si	lver Spri:	n g		10g. Citizen of What C	country?
	with ta or									
	eath	era	11020 Cone Lane 11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No	USA 14. Race - Am	erican Indian,
	fter d	Funeral	1 ☐ Never Married 2 Married	Armed Forces? d 1 ☐ Yes 2 🔀 No		If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
38	al', or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 😿 No	Specify:		Specif Wh i	te
21215-0036	2 hou	Completed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	eation	lulas as	16b. Kind of Busines	s/Industry
72	in "n Medi	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of worl d)	ang		
21	d with	Ę	12		Secreta	ary			Governme	nt
٦	be filed within 72 hours after death with the Maryland tall Hyglene. d dther than "natural", or flems 23a or 28a-f show dother than "natural", or flems 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, La	ast)			18. Mother's Nam	e (First, Middle	, Maiden Surname)	
<u>a</u>	Alenta Alenta rrked	10	Nicola Ruggieri	•			Amelia	Rotundo) 	
Maryland	s ma		19a. Informant's Name/Relationship		19b. Maili	•			er, City or Town, State,	
Σ	and 2 ealth 1 27 I er tra		Vincent Cicala/F	lusband 			ne Lane,		Spring, MD	
altimore,	of He		20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce) Tan	Date . 17,	20c. Location - City of	r Town, State
Ĕ	Pag nent ant: I		4 □ Donation 5 □ Other (Spe	ecify)	Arlington	National	Cemetery	2008	Arlington	, VA
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	censee	2	2. Name and Addre	ss of Facility Collins	Funera	1 Home Inc	
Ω	6 3 E E 6	N .	James 7	Jashy		500 Unive	rsity Bly	d. W. S	Silver Spri	
П			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that daused the one cause on each line	ne death. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition	_a Communit	r Securites	d Drauman	4.0			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):	CI E LIMMON	nt a			
	Examiner		Sequentially list conditions,	D	Obstructi	ve Pulmon	ary Dise	ase		
	p Æ	Examiner	riany, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
	ecute ind trans	am	that initiated events resulting in death) Last	C						
8760,	icate be executed physician and s the burial-transit	E E		Due to (or as a	consequence of):					
87	ate to	dical	`	d						
9	leath certific attending p	Me	IF FEMALE:	22a If you guttoome n	f programov				001544	
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	Fetal death 3	□Ectopic pregnanc	у		23d. Date of d Month	Day Year
0	the a	Physician/Me	1 ☐ Yes 2 🔼 No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or death 5	Other (specify)				
	requires that the death certificeen signed by the attending poould be detached for use as	P.	Part II. Other significant condition	' s contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use contribute	to the cause of death?
S,	ires t signe	by						10	Yes 2∐ No 3½	Probably 4 Unknown
Ö		Completed	Coronary Artery	ursease				04- 14/	Oth W	
3ec	2 38 2	현		···				24a. Was		autopsy findings available o completion of cause of
#	(Q CZ	Ç						1□ Yes	2 No 1 □ Y	es 2 No
Vital Records,	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ant all DOA Oth	26. Place of Dea	,		
o	this a	မ	1 ☐ Yes 2 ☑ No	1 ☐ Inpatien 28a. Date of Injury		SIR SLIDON	4 🗀 Nursing H		idence 6 Other (S)	pecify)
n C		ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day		Wo	rk? Yes 2∐No	20d. Describe	now injury occurred	
<u>S</u>	Attending r death. sctor: After oy the fune	cat	2 Accident investiga 3 Suicide 6 Could no	ot be 28e Place of injur	y - At home, farm, s		7103 2 110	28f Location	(Street and Number or	Rural Route Number
Division	or A after of Direction by	Certification:	4 ☐ Homicide determin	building, etc.		aroot, taotory, ornoc			own, State)	ridia, ribale riamber,
1	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 12 Certifying	Physician: To the best of	my knowledge, dea	ath occurred at the ti	ime, date and place	e, and due to the	e cause(s) and manner	as stated.
	24 ho Fun etely	Medical	(Check only 2 Medical E	xaminer: On the basis of e	examination and/or i	investigation, in my	opinion, death occu	urred at the time	, date and place, and d	ue to the cause(s)
	To the language within 24	Me	29b. Signature and title of dertifley			29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
			Here of the		X		D53337		January	4, 2008
	7	1	30. Name and address of person w	h completed cause of dea	ath (Item 23a) (Type	e, Print)				
			Dorothy Seay, M		th Avenue		altimore	, MD 21:	209	
B	Sta	ite	31. Date filed (Month, Day, Year)							
	Registi		JAN 09	2008	's Signature	Marie D				

DHMH 17 Rev 1/2001

			-				delible Ink. artment of H		-	Are Legible.	
		1	1 - For State Registrar				rtificate of l			Reg. No.2 () () 8	01581
	Physicia	an	Decedent's Name (First, Middle						2. Date of De Month	ath Day Year	3. Time of Death
25%	/Medic		Doreen L. Ca							ARY 0320	
	Examin	er	4a. Facility Name (If not institution Doctors Comm			ı	4b. City, Town, or Lanh		n	4c. County of Dea	George's
- 3	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		
Ė	Director		168-46-7272 Usual Residence of Decedent	1□M 2XTF	54	1 Yrs.	Months Days	Hours Min.	Dec 1	2 1953 Pe	rthplace (State or Foreign country) ennsylvania
	yland low at		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	a-f sh	ctor	Maryland Prin	ce Geor	ge's	Uŗ	per Mar	1boro			1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	sath v	eral	105 Big Chim		nch cedent Ever in U	S 12	2077		thosify Vos or No	USA 14. Race - Am	erican Indian
	fter de r item iner r	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F ied 1 □ Yes	Forces?		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, Wh	
99	2 should be filed within 72 hours after death with the Maryland and Merlat Hyglene. and Merlat Hyglene is marked other than "natural" or items 23a or 28a-f show is marked other than "natural" or items 20a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	3 Widowed 4 Noivorced	If Yes, C Year or	Dates:		1 ☐ Yes 2 X No	Specify:		Specify: B1	.ack
and 21215-0036	72 hg	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Business National	
7	within ene. than he Me	dmo	Elementary/Secondary (0-12) 12th	College 2 v	(1-4or 5+)		<i>DO NOT use retired</i> Stomer S				gro Women
5	filed I Hygi other ent, t	BeC	17. Father's Name (First, Middle,		<u> </u>	_ Cat	JOINET D			, Maiden Surname)	gro women
	ute be Wental irked o	일	Thomas Colem	an				Doroth	ıy Watk	ins	
Mary	2 should and Mer is marke raumatio	·	19a. Informant's Name/Relations		`	i .	-				Zip Code) 20774
	s 1 and 2 should f Health and Mer ftem 27 is marke other traumatic		Carliece Lee 20a. Method of Disposition	(Sister	·		114		Date U	pper Marl	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If fem 27 is any injury or other trai		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				osition (Name of matory or other place Cremator		9-08	Baltimor	
alti.	permit. F Departme Importan any injur		21. Signature of Funeral Service					4 !	s Mort	uary, P.A	
m	an Jed		Fary B.	Reese M	00483	8	321 West	St. An	napoli	s, Md. 21	401
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	tapho	*	ccal B	ueter	euma		Oriset and Beaut
40	Examiner		,	Due to	o (or as a conse	rui nce of):	1.19-				
	3, ≥	Jer	Sequentially list conditions,	b. Due to	(or as a conseq	juence of):	4	,			
	executed n and ial-transit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	'and	suc	Arnes	}			
60,			resulting in death) Last	Due to	o (or as a conseq	luence of):					
687	ficate be physicials the bur	Physician/Medical		d							
Вох	feath certific attending pl	In/M	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna		∃Ectopic pregnancy	,		23d. Date of d	elivery
O. B	e deat he atte ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of c		Other (specify)	, 		Month	Day Year
٦.	res that the de signed by the a be detached t	Phy	9 ☐ Unknown Part II. Other significant conditi			sulting in the u	nderlying cause give	en in Part I	23e Did t	tobacco use contribute	to the cause of death?
Records,	he law requires that the death certificate be te has t een signed by the attending physicis age 2 should be detached for use as the bu	d by	Takin other organization	one commoding to	addin barnor roo	and in the d	riddifyllig daddo giv	on are a	1 🗆	01	Probably 4 □Unknown
Ö	av require s t een sig	Completed	7						24a. Was		autopsy findings available
	he lav	mo	-						autoj perfo 1∐ Yes	ormed? death?	completion of cause of
Vital	ician: h certificate ector, pag	Be C	25. Was case referred to medica examiner?						ath (Check only o		
	this aldir	မ	1 ☐ Yes 25 No 27. Manper of Death		npatient 2 □ e of Injury	ER/Outpatier		4 🗆 Nursing F	1	dence 6 Other (Sp	ecify)
on	Jing Afte Fune	tion	1 Natural 5 Pendir	g (Mo	onth, Day Year)	Injury	Wor	yat k? Yes 2∐No	Zod. Describe	now injury occurred	
Division or	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could determ	not be 28e. Plac	ce of injury - At he	ome, farm, sti	reet, factory, office		28f. Location (: City or To	Street and Number or F	Rural Route Number,
ā	Hospital or A	Cert	T I TIONII GIGG	Dul.	unig, etc. (opeon	.,,			City of 10	,, outo,	
	e Hospital of 24 hours alletely filled i	Medical		Examiner: On the						cause(s) and manner a date and place, and di	
	To the Hos within 24 ho To the Fur completely	Mec	29b. Signature and title of certifie		mer stated.		29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
}	C > F 0		* Eleur V	mm)	MD		DE	7295		Sania	wer 4,7008
,	211		30. Name and ad reg s of pe son	who completed car	use of death (Iter	m 23a) (Type,	Print) Profer-Print	0 0	[11 1		my 4,7008
1	CAN		DIVYAVERW 31. Date filed (Month, Day, Year)	4 1765	Green	way(t	wer priv	e, brees	useltib	MD 2077	-0
	Sta Registr		JAN 0	8 2008	gistrar's Signa	# 1	berte				
DHI	MH 17 Rev 1/20	001			No.	-7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** P 2008 January 4, Stewart Charles Cole /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Future Care Chesapeake Arno1d If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/21/1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□F Washington, 77 579-34-5124 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Anne Arundel Riva Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21140 102 Ridge Rd, #102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1950-52 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 XX lo Specify: White altimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Communications 12th Communications Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown Mildred ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5114 Parklawn Terr., #301, Rockville, MD 20852 Scott E. Cole/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t = 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any Injury or MD Veterans Cemetery 1/9/08 Crownsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ephrosderosis Immediate Cause (Final disease or condition resulting in death) 6 N **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? 1 ☐ Yes 2 No 1∐ Yes 25 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. filled in by the funeral after death. within 24 hours a To the Funeral I

28a. Date of Injury (Month, Day Year) 1 atural 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of extifier 32036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Cherter, MB 2/4/9

Bitata Registrar

31. Date filed (Month, Day, Year)

32. istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar		aryland / Dep		Health and	Mental Hyg	giene	01583
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath	3. Time of Death
	Physici /Media	al	RALPH	E.		OOK City Town	as Location of Dogs	JAN.	Day Year 2 2008 4c. County of Deatl	5:50 P ^M
	Examir	er	4a. Facility Name (If not institution, giv			,	or Location of Deat	n		
			ATLANTIC GENERA 5. Social Security Number 6. S		u ge (In yrs. last birthday		RLIN r If Under 24 Hrs	8. Date of Birtl	WORCES	
	Funeral Director		219-26-3807	M 2□F	67 Yrs.	Months Day:			y, Year) Co. 1940 NE	nplace (State or Foreign untry) W YORK
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	death with the Maryland ime 23a or 28e-f ehow	Director	DELAWARE SUSSE	X	SELBYV					1 □Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
	23a	ai	36924 MALLARD D	RIVE		199			USA	
	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental hygiene. If Health and Mental Hygiene a factories or items 23a or 28e-f show them 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.	Hispanic Origin? (S ban, Mexican, Puer o Specify:	Specify Yes or No- to Rican, etc.)		
Maryland 21215-0036	within 72 ho ene. than "natur ne Medical	pleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or	(Give	edent's Usual Occi s kind of work don DO NOT use retir	e during most of wo	rking	16b. Kind of Business/	ndustry
7	d with	ě	12	College (1 40)	5.7,	BUILDER	L		CONSTRI	JCTION
Þ	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
<u>a</u>	ould be Mental arked o	ToE	PHILIP	COOK			HAZEI	4	JACKSON	
ar	2 sho and h ie ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Stree	at and Number or Ri	ural Route Numbe	r, City or Town, State, Z	lip Code)
	and 2 vaith n 27 l		MARJORIE L. COOK	/WIFE				SELBYVII	LE, DE. 199	975
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: if item 27 is eny injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Pamoual from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pi	ace)	Date	20c. Location - City or	Town, State
Ĕ	Pag nent: I		4 □ Donation 5 □ Other (Special		1		MARVA 1/3	3/08	DELMAR, DI	ELAWARE
a E	permit. Departn Importe eny inju		21. Signatur of Funeral Service Lice	S86	2	2. Name and Add	ress of Facility			
m	88558		Wuster W	Han I	H	ASTINGS	FUNERAL H	IOME, SEL	BYVILLE, DI	E. 19975
	Physician /Medical Examiner	Examiner	Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, and leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	a consequence of:	ncer				Onset and Death
	cate be executed bhysicien and the burial-transit	icat	resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box 6	The law requires that the death certificate be executed are has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of deli Month	very Day Year
rds, P	w requires thet been signed b should be deta	ed by P	Part II. Other significant conditions of	contributing to death t	out not resulting in the	underlying cause g	given in Part I.	23e. Did to	obacco use contribute to Yes 2 No 3 Pro	the cause of death?
Il Records,	The law re cate has being page 2 sho	Complet						24a. Was autop perfor 1 Yes	rmed? prior to death?	topsy findings available completion of cause of
/ite	cien ertific	Be	25. Was case referred to medical examiner?	11				ath Check only o	ne)	
7	hysi this c	P.	1 ☐ Yes 2 📉 No	Hospital: 1 Inpati		INT 3 DOA			dence 6 □Other (Spec	cify)
Division of Vital	inding Path. r: After t	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju (Month, Da	ury 28b. Time (lnjury	W	uryat ork? ∐Yes 2∐No	28d. Describe h	now injury occurred	
Divis	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of In	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office	9	28f. Location (S City or Ton	Street and Number or Ru vn, State)	ral Route Number,
	Mospi 124 hours 14 Funer letely fills	Medical	29a. Certifier (Check only one) 11 Certifying Pl	ysician: To the best niner: On the basis of and manner st	of examination and/or is	th decurred at the nvestigation, in my	time, date and place opinion, death occur	urred at the time,	caus (s) and marrier as date and place, and due	to the cause(s)
	To th To th Somp	Me	29b. Signature and title of certifier	. ()			nse number		29d. Date signed (Monti	h, Day, Year)
)	SAR		Aft?	イ・リ			064120		1/2/08	
-	J		30. Nam ind address of person who Zeeshan Atit	AGH 97:	33 Healthu	vay Driv	e Berli	n M.D	21811	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	Goode				

1001 7:80

DOB: 5/6/40 DOD: 1/2/08

100x, xalph 20# 0/9-26-5801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1:00 P M JANUARY 2008 COLE BOBBY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HYATTSVILLE PRINCE GEORGE'S 3414 55th AVENUE # 204 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 2□ F TEXAS 1957 50 MAY 6 Director 462-13-1944 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Directo PRINCE GEORGE'S HYATTSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20784 USA 3414 55th AVENUE # 204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examina-1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ⋛ ☐ No BLACK Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE PLUMBER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PATRICIA COLE JAMES COLE SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HOUSTON, TEXAS 77081 6220 ALDER DRIVE # 4141 PATRICIA COLE/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Clemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARDISE SOUTH CEMETERY 1/12/2008 HOUSTON, TEXAS 22. Name and Address of Facility ral Service License J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician esphorator /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examine Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 ☐Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ★ No 24a. Was an certificate has autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25KN0 1 🗀 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

5

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 09

2008

30. Name and addre

DHMH 17 Rev 1/2001

29c License number

Center Drive

29d. Date signed (Month. Dav. Year)

and manner stated.

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

			1 - State Registrar	State of M	arylan	-	artment of I r <i>tificate of</i>				giene Reg. Na) (HEDE
4.4	Dharalai	*	1. Decedent's Name (First, Middle, Las	t)					- 1	2. Date of De Month	ath	C 0 0 (3	Time of Death
	Physici /Medic	al	Leah Carter	-44			4b. City, Town, o	Location	of Dooth	1	5 5	2008 c. County of Dec	3	7:50 A ^M
1	Examin	er	4a. Facility Name (If not institution, give				Rockvil.		or Death			lontgome		
	Funeral Director		5. Social Security Number 6. Se		ge (In yrs. 5	last birthday) 4 Yrs.	If Under 1 Year Months Days		Min.	3. Date of Bird (Month, Da 1/21/1	th y, Year	9 Bi	rthplace ((State or Foreign
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. In	side City Limits
	Maryk f sho	tor	MD Montgomen	^T77		ville								¥∑Yes 2 □ No
	r 28a	irec	10e. Street and Number	- У	HOCK	VILLE	10f. Zip Code				10g. Ci	itizen of What C	Country?	
	23a c ust be	ralD	4506 Falcon Court				20853				Unit	ed Stat	tes_	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces: 1 ☐ Yes 2 If Yes, Give Year or Dates:	Ever in U ? No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No	lispanic Ori an, Mexical Specify:		ify Yes or No ican, etc.)	-	14. Race - Am Black, Wh Specify: B		dian,
5-0	72 ho 'natur di al	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	oation during mos	st of working	7	16b. l	Kind of Busines	s/Industry	
12	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		oo nor use retire strative				Α.	S.H.P.		
<u>d</u> 2	i filed I Hygi other ent, ti	Be Co	17. Father's Name (First, Middle, Last)			riamizmo	, clacive	18. Mothe	er's Name (First, Middle		n Surname)		-
/lar	wild be Menta arked	To B	Albert Carter					Geor	gia U	nknown	l 			
, Maryland	and 2 sho salth and I n 27 is me er traums	·	19a. Informant's Name/Relationship (7 Karen M. Braxton	ype. Print) Nie		11230	ng Address (Street) Evans T	rail B						
Baltimore,	ges 1 t of He If Iten or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐	Removal from State	20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other pla	1	Da		20c. L	ocation - City o	r Town, S	State
Ē	it. Pa irtmen irtant: ifury		4 □ Donation 5 □ Other (Specify 21. Smature of Funeral Service Licep		Riv		Cremato Name and Address		1/11/:			erdale,		
Ba	Derm Depa Impo any i		Juan Smel	S		30	015 _, 12th	Stree	et NE	Washir	ngto		20017	
			23a Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	olications that cause one cause on each I Breast	ine.		er the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Inte	roximate rval Between et and Death
}	Physician /Medical		disease or condition resulting in death)	a. Due to (or as										
	Examiner			b	a conseq	defice oi).								
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or Injury	Due to (or as	a conseq	uence of):								
	recute and -trans	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consec	uence of):							-	
68760,	icate be executed physician and s the burial-transit	edical E		.d		30.100 0.71								
	ertifical ing phy e as th		IF FEMALE:											
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	al death 3	Ectopic pregnand Other (specify)	у				23d. Date of d Month	elivery Day	Year
	res that the de signed by the a be detached i	by Ph	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	nderlying cause gi	en in Part I	l.	23e. Did t	obacco	use contribute	to the ca	use of death?
ğ	w require been sig should b						_			10	Yes 2	2□No 3□I	Probably	4 X i∪nknown
Records,	has be	Completed								24a. Was	psy	24b. Were a	autopsy fi complet	ndings available ion of cause of
e H	: The icate ha									perfo 1∐ Yes	rmed? 2X N	death? o 1 □ Ye		No
Vital	nyslclan: Th nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2X No	Hospital: 1 ☐ Inpati	iont 3	ER/Outpatier	nt 3 DOA Oti	oer:		Check only o		6 Potter (6)		
0	ding Phy h. After this funeral d		27. Manner of Death	28a. Date of Inj	ury	28b. Time o	" JU DOX	4 L N		Bd. Describe		6 ☐Other (Spury occurred	ecity)	
joi	tendin leath. tor: Aft the fun	atio	1 Natural 5 Pending 2 Accident investigation		ay rear)	Injury		Yes 2	lNo					
Division or	l or Att after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in building, e	jury - At he tc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, office		28	If. Location (City or To		and Number or I te)	Rural Rou	ite Number,
	To the Hospital or Attending Physician: within 42 Hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p.	Medical C		ysician: To the best liner: On the basis of and manner si	of examina									
	To the within Fo the comple	Mec	29b. Signature and title of certifier	11/		,	29c. Licens	se number			29d. D	ate signed (Mo	nth, Day,	Year)
	, , , , ,		1 grenere	- Will	2	W	D00	64615			1/7/	/2008		
1			30. Navie and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)		100 P	0.01	1.0	Max-1 -	nd O	1850
			Dr. Genevieve Wrol 31. Date filed (Month, Day, Year)	olewski I			Drive,S	arre	100 K	OCKVIL	TE,	rary1a	110 21	0000
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year Month **Physician** 15AM 2003 William A. Chenoweth, Jr. Tan /Medical 4a. Facility Name (ff not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore City Baltimore
If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs 216-07-8029 Director 07/30/1917 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 □YYes 2 □ No Baltimore Funeral Director Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 238 2802 Pinewood Avenue 21214 USA permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 3 any injury or other traumatic event, the Medical Examination once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Office manager / Rater Trucking Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William A. Chenoweth, Sr. Marie Herald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Thelma Frazier Niece 4656 Smoketown Road, Glenville, PA 17329 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Carroll Cremation, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 01/08/2008 Hamustead, MD 21074 22. Name and Address of Facility
Kenworthy Funeral Home, Inc.
269 Frederick Street, Hanover, PA 17331 21. Signature of Funeral Service Licensee CC0354 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myscardial Physician Acuite /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ D 2D 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 1 ∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X**No Other: 2 ER/Outpatient 3 DOA 1 Inpatient 2 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specily) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accider 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m Willen 45757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Au Bolt, Mi Zezzy Matthew Minkbury 4846 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 0 8 2008

DHMH 17 Rev 1/2001

Registrar

Il deron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 06 12:00 PM 2008 FRANCES ONEIDA CHRISTY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPTIAL HAVRE DE GRACE HARFORD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F Yrs. 70 Director 219-34-2369 DEC 13, 1937 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show it. Peges 1 and 2 should be filed within 72 hours after death with the Maryla utment of Health and Mental Hygiene. writent: If item 221e marked other then "nature!, or Items 23e or 28e-1 ehov nlury or other fraumatic event, the Medical Examination and the natified at 1 X Yes 2 ☐ No MARYLAND HAVRE DE GRACE HARFORD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 GILES STREET, APT 1 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 DOMESTIC PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RALPH WEBSTER CATHERINE HOOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCUS HARRIS / SON 5185 ILCHESTER WOODS WAY, ELLICOTT CITY, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I eny Injury o once. 4 □ Donation 5 □ Other (Specify) ST. JAMES CEMETERY 01/12/08 HAVRE DE GRACE, MD 22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET, HAVRE DE GRACE 21. Signature of Funeral Service Licensee dia Statt-Colema MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day 4 Pregnant at time of death 5 Other (specify) certificate hes been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1 Yes 2√ No Fo the Hospital or Attending Physician: 25. Was case referred to edical examiner? funeral director, 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 X ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 1 Tes 2 No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funerel C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) 2008 9

MD. DME 1614 CHYRCHVILLE Rd

Lause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

BA7

State Registrar

DHMH 17 Rev 1/2001

10445 Ocean City

32. Registrar's Signature

Suite 1

Barlin MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abbott mo

JAN 1 0 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

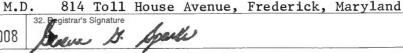
			For State Registrar	State of Maryla	•	artment of H		, -	ene 2008	01589
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia /Medic		Angelica	Luisa De	Leon			Jan.5,	2008	1:07 ам
	Examin		4a. Facility Name (If not institution, give 9301 Gue Road	street and number)		4b. City, Town, or Damas	Location of Death		4c. County of Deat Montgo	mery
	Funeral Director		5. Social Security Number 6. Set 217-35-5202	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6 / 21 / 1	9. Birt Co 942 Gu	hplace (State or Foreign untry) atemala
	p ,		Usual Residence of Decedent 10a, State 10b, County	100.0	ity, Town or Lo	ocation				10d. Inside City Limits
	Marylar 1-f ehow	tor	MD Montgon		Damaso					1 ☐ Yes 2 ☐ÑNo
	h with the	Funeral Director	10e. Street and Number 9301 Gue Road			10f. Zip Code 20872		10	og. Citizen of What Co Guatemal	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural, or items 23s or 28s-f show any injury or other traumatic event, the Madical Examinar must be notified at anone.	y Funer	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 (\$\frac{1}{2}\$No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1₺ Yes 2□ No	lispanic Origin? (Span, Mexican, Puerto Specity:	Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
8	ural',	d by	3 Widowed 4 Divorced		162 Door	dent's Usual Occup	Specify: Guate		16b, Kind of Business	
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and 2	id be filed ental Hyg ked other c event,	To Be C	17. Father's Name (First, Middle, Last) Feliciano Soto				18. Mother's Nam.		Maiden Sumame) la Grama	jo
Maryland	d 2 shoul th and Me 17 le mark traumati	I	19a. Informant's Name/Relationship (T) Ismar Martin De						City or Town, State, aryland 2	
ore,	ges 1 an of Heal If item 2 or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 The state of the state of	20b.	Place of Disponentery, cre	osition (Name of matory or other place)	(P) 1/15	Date 5/2008	20c. Location - City or Quetzalte	Town, State
Baltimore,	permit. Pag Department Important: any injury o		4 □ Donation /5 □ Other (Specify) 21. Signature 1/2 neral Service Licens	Mı	inicip P	al Ceme HYTETP^db	tery ::R'IN'ALDI	FUNER.	Guatemala AL SERVI	CE, P.A.
<u>@</u>	89689		23a. Part1. Enter the disease, or comp	ications that caused the de						Approximate Interval Between
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	/Medical		disease or condition resulting in death)	aLIVER C		SIS				
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Box 6	ne death certificate be executed the ettending physicien and shed for use as the burlat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
9, P.O	law requires that the de as been signed by the E 2 should be detached i	by Ph	Part II. Other significant conditions co	ntributing to death but not re	esulting in the	underlying cause gr	ven in Part I.		bacco use contribute t	
ğ	w require been sig should b		Alcoholism					1 □ Ye	es 2. 22No 3. □ P	robably 4 DUnknown
Vital Records,	The hade	ompleted						24a. Was a autops perform	med? death?	utopsy findings available completion of cause of
ita	certifical rector, p	BeC	25. Was case referred to medical examiner?					th (Check only on		
o V	Physician: this certific ral director,	2	1 ☐ Yes 2 ② No	1	□ ER/Outpatie	IN 3 DOA			ence 6 Other (Spe	ecity)
ono	ding After fune	tion:	27. Manner of Death 1	28a. Oate of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk?]Yes 2 ☐ No	28a. Describe no	ow injury occurred	
Division	al or Attend efter death I Director; d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe		treet, factory, office		28l. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	To the Hospital or Atti within 24 hours efter de To the Funeral Direct completely filled in by ti	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my k iner: On the basis of exami and manner stated.	nation and/or i	ath occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	, and due to the c rred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	2	-	29c. Licen	se number	2	9d. Date signed (Mon	ith, Day, Year)
) _	7		1/11	M		D5	2382		Jan.3,2	800
)		30. Name and address of person who do nanilo Moli				Rd #260	Rockvil	lle,Md 20	852
	St: Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 9 20	32 eğistrar's Sig	mature A	and i	=			

State Registrar

31. Date filed (Month, Day, Year) **JAN 1 1** 2008

Sibte A. Kazmi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



January 10, 2008

08-00123 Kyle Joseph Dixon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amended item#2, WCHD, 01 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death Phystician/ 1. Decedent's Name (First, Middle, Last) 2225 hrs January 4: 2007 2008 Medical Examiner Kyle Joseph Dixon c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Penninsula Regional Medical Center If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY g. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Hours Months Days Country) Oct. 29, 1991 Director 1 X M 2 F 221-82-1163 16 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No 23a or 28a-f show notified at once. DE Sussex Delmar jes I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number U.S.A. 19940 ᡖ 215 North Hantwerker Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nouneral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be White, etc. Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify 屲 Yes 2 X No specify: white f Yes. Give Year Divorced If item 27 is marked other than "natural", her fraumatic event, the Medical Examiner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 high school student 10 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annette Massey Be Joseph Harvey Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ 215 N. Hantwerker Drive Delmar, DE Joseph H. Dixon (Father) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Jan. 9, 2008 Delmar, Delaware Stephens Cemetery Donation 5 Other Specify. 22. Name and Address of Faci 21. Signature of Funeral Service Licensee hort Funeral 3 East Grove Home Street DE 19940 Delmar. XUI Approximate Interval aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a, Part I. Inter the disease, or confailure. Between Onset and Physician Death /Medical a. Multiple Injuries Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED tending physician use as the burial The law requires that the death certificate be P.O. Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte I be detached for u 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available Records, 24a. Was an certificate has been a prior to completion of cause of autopsy death? performed? ✓ Yes ✓ Yes 2 No page 26 Place of Death (Check only one) To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Division of Vital Be Other₄ examiner? Residence 6 Nursina Home 5 DOA Inpatient 2 V ER/Outpatient 3 this 1 ✓ Yes No 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Passenger auto auto collision Certification: Jan 4, 2008 2140 hrs Yes 2 V No Natural Director: Pending 24 hours after death. 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Dagsboro Road and Parsonsburg Road, Salisbury, MD 3 Could not be Suicide determined (Specify) Local Street 4 Fo the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 5, 2008 O.C.M.E. amorie 30. Name and a dress of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. 32. Regitrar's Signature 31. Date filed (Month. State 9 2008

Registrar DHMH 17 Rev 1/2001

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Registrar

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended item#7,01/14/08,SLIC, Weing ate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Year 01 2008 Bell Dickinson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner legional medical Peninsula NICOMICO 5. Social Security Number 8. Date of Birth 10/30/1918 thplace (State or Foreign (Month, Day, 10/4) 6. Sex **Funeral** Months Days 1 □ M 2**%** □ F Director North Dakota 212-12-3855 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21801 USA 611 Tressler Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No δ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s marked other than College (1-4or 5+) Elementary/Secondary (0-12) Secretary Department of Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be lealth and Mental Edna Maud Parsons Philip Grant Dickinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health or Important: If item 27 is any injury or other trau once. 2006 Cambridge Dr. Crofton, Maryland 21114 Elizabeth Wilkins/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/05/2008 Salisbury, Maryland 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd. Salisbury, Maryland 21804 21. Signature of Funeral Service License 16.11 A trener 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxemic Du (or as a consequ **Physician** /Medical (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-tran Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform page certificate 2 No 1□ Yes ctor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

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31. Date filed (Month)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VOHRA

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614 EASTERN SHORE DR. SALISBURY MD

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2008 nuarya Ja /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Hospital Laurel Regional Laurel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 11/15/1949 El Salvador Hours 1 XM 2 □ F 58 215-39-5865 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 No Laurel MD Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. El Salvador 20723 9005 Dumhart Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② WNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Hispanic 1 X Yes 2 □ No Specify Salvadorean Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' any injury or other traumatic event, the Me College (1-4or 5+) Window Cleaning High rise window washer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Teodolinda Arevalo Gabriel Davila ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9005 Dumhart Rd. Laurel, MD 20723 19a. Informant's Name/Relationship (Type. Print) Blanca Iris Davila / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/07/08 Annandale, VA Pleasant Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Demaine Funeral Home 5308 Backlick Rd. Springfield, VA 22151 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical nsequence of) Examiner 2-Car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-trai Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 No 3 Probably 4 Unknown 1 ☐ Yes cate has been sig , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ◯ No 24a. Was an autopsy performed 2€ No Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed

32. Registrar's Signature

Laurel

egiona

death (Item 23a) (Type, Print)

Amended Item 20b per F.D. 01/07/2008 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nancy Lou Dedmon OI 8008 07.05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital Center Carroll Westminster arroll 8. Date of Birth (Month, Day, Sept 07 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1932 1 □ M 2 1 1 Months Days Hours Min. 75 W. VA Director 235-50-4932 the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Directo MD Carroll Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the M. ical Examiner must be n 209 Carroll Heights Road 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 2+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas L. Scott Madge Sparks ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald A. Dedmon/husband 209 Carroll Heights Road Taneytown, MD 21787 20a. Method of Disposition 20c. Location - City or Town, State St. cell-att, credit the hanacem. 01/07/2008 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Uniontown Lutheran Cemetery Uniontown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home 412 Washington Road 21. Signaturé of Funeral Service Licenses aut A 21157 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Puenmonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Disseminater wtravascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, use as attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has certificate ha perform 2 No To the Hospital or Attending Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 146 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □Pending investigation 1 Natural (Month, Day Year) Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066295 ow 2008 172 30. Name and address principles of person with completed course the (Item 1999) (Type, Print) MANAGEMENT LTD. THYSICIAN 200 Memorial Avenue Westminster, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 23a per dr., 8876,02/16/08dhb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 3, 2008 1:11 P January Sarah Virginia Estep /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 816 Midship Court Annapolis 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2**X** F 3/1/1926 Pennsylvania Director 188-20-7255 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event than "natural". 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Annapolis Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 816 Midship Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Sellers Benner Wilson ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 19a. Informant's Name/Relationship (Type. Print) 5542 Karenelaine Dr., Unit 1514, New Carrollton, MD Cindy Estep/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 1/8/08 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of unal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onser and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Year Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Hypertension and resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1□Yes 2□No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? #33A \Rightarrow Division or Vital Records, ģ No. 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1∐ Yes 2[Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on 1 ☐ Yes 2/2/No 27. Manner of Death Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 5 Residence 6 DOther (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No ✓ □ Accident completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29 Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who mpleted cause of death (Item 23a) (Type, Print)

<u>Michael</u> J. LaPenta, 31. Date filed (Month, Day, Year) State JAN 0 7 2008

Nam and address of persor

445 Defense Hwy., Annapolis, MD 21401 32. pegistrar's Signature deve

M.D.

Spell

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	/ Department of Hea		Hygiene 200	8 01597
			Decedent's Name (First, Middle, La	st)		2. Date	of Death	3. Time of Death
	Physici /Medic		Virginia EW	e_11		Monti	h Day Ye	
	Examin		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Loca	ation of Death	4c. County of [
				using home	- Salisbu	M Index 24 Hz	Wico	
	Funeral		5. Social Security Number 6. S	Fex 7. Age (In yrs. las		Jnder 24 Hrs. 8. Date (Mont	or Birth th, Day, Year)	Birthplace (State or Foreign Country) IRGINIA
	Director	1	Usual Residence of Decedent	, 10		7-	23-1/ V	TREINITH
	yland		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	B Mar	ctor	VA ACCI) MUCK I HT	antic			1 □ Yes 2 No
	or 28	Dire	10e. Street and Number	l andi-	10f. Zip Code	カク	10g. Citizen of Wha	it Country?
	within 72 hours atter deeth with the Maryland ene. then "neturel", or items 23a or 28a-f show he Madical Examine: must be notified at	Funeral Director		anding 12, Was Decedent Ever in U.S.	13 Was Decedent of Hispar	oic Origin? (Specify Ves	or No. 14 Bace -	American Indian,
	ter de	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. Was Decedent of Hispar If Yes, specify Cuban, M	exican, Puerto Rican, et	c.) Black, V	White, etc.
215-0036	al', or	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 No St	pecify:	Specify:	BIACK
5-0	72 ho	Completed by	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occupation (Give kind of work done during	g most of working	16b. Kind of Busin	Section 1
121	within ene. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Line-Worke	0 1	Holly	FARMS
N	filed v Hygie ther t		17. Father's Name (First, Middle, Last)			fiddle, Maiden Sumame)	DULIET
land	2 E 5 2	To Be	George D.	Talian		Janie	Susan	tletcher
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9	tificate ig phys as the	ledi						
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand			23d. Date of Month	
	res that the death certifics igned by the attending ph be detached for use as t	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown				Day
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Division	or At after of Direction by	Certification;	4 Homicide determined		e, farm, street, factory, office		or Town, State)	or Aurai Aoute Number,
_	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page.	alC	29a. Certifier Certifying P	hysician: To the best of my knowl	edge, death occurred at the time, o	late and place, and due	to the cause(s) and mann	er as stated.
	he Ho in 24 l he Fu pletely	edical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	on and/or investigation, in my opinio	on, death occurred at the		
	To t To t	ž	29b. Signature and title of certifier	CIAR (LOCA)	29c. License nu	mber	29d. Date signed (
	ngh		1. Ambor	NO [VII]	D006	3441	1-4	- 2008.
	20		30. Name and address of pers in who			Rich Kalina	0 -11	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** Rodrigo G. Figueroa Jan 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery National Institutes of Health Bethesda 8. Date of Birth (Month, Day, Year) 12-08-1973 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Days Hours Min Ecuador Director UNK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Westchester Elmsford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15N Goodwin Avenue 10523 Ecuador Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Spanish 1√2 Yes 2 No Specify: <u></u> 3 Widowed 4 Divorced Ecuadoran Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Perez Luis Figueroa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pedro Figueroa/Brother 10523 15N Goodwin Avenue Elmsford, NY 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 01-10-2008 Corona, NY 4 ☐ Donation 5 ☐ Other (Specify) Rivera Funeral Home 21. Signature of Tu 22. Name and Address of Facility Marshall's Funeral Home, Inc. Washington, DC 20011 4217 9th Street, NW plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death er the disease, or comp heart failure. List only o Immediate Cause (Final **Physician** disease or condition resulting in death) CVEEK /Medical Due to (or as a consequence of): Examiner 1)ISFASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit LEVKENIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy 2 1 No 2 No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 10 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 ☐ Yes 2 ☐ No I Director: d in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760.

death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Fo the Hospital or Attending Physician: this death. hours after within 24 hours a To the Funeral C

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

31. Date filed (Month, Day, Year, JAN 1 0 2008 JAN 1 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ERBERT **Physician** ERGUSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 6040 Sargeant Road #4106 Hvattsville Date of Birth (Month, Day, Year) 7/14/1925 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **7**M 2□F Months Days Hours Texas 466-30-3401 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Event. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Hyattsville 1 XYes 2 No Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6040 Sargeant Road #4106 20782 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 1945—
If Yes, Give Year or Dates: 1965 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Boiler Engineer U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Knotts Fannie Wolford 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20782 3604 Longfellow Street, Hyattsville, MD Howard Ferguson - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 TxBurial 2 □ Cremation 3 □ Removal from State Arlington National Cem 1/24/2008 Arlington, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensy 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 | Fetal death 3 DEctonic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 2 ☐ No 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🔲 Yes 25 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death.

Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier

CR (4)+1

State Registrar 31. Date filed (Month, Day, Year)



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The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attanding Physician: within 24 hours a To the Funaraf C

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altimore, Maryland 21215-0036

nd address of person who completed cause of death (Item 23a) (Type, Print) MILLIM HULL . Date filed (Month, Day, Year) 32. Rea State JAN 1 0 2008 Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29c. License number

29d, Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** '0555M HOL ETH 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2213 Hyde Lane Prince Georges Bowie | FUNDER | 1 | FUNDER 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 22, 1 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🔀 F Director 217-82-4612 46 1961 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f shov ner must be notified at Maryland Wicomico Salisbury 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 215 New York Avenue 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. filed within 72 hours after 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service g 18. Mother's Name (First, Middle, Maiden Surname)
Gloria Datz 17. Father's Name (First, Middle, Last) Be Paul Glaser 1 and 2 should be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2213 Hyde Lane, Bowie, MD 20716 Gloria Goverman, Mother permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other ti 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery | 01/09/08 21. Signature of Funeral Service Licens Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): the death certificate be executed Exam burial-trai Due to (or as a consequence of): physician at the burial Box 68760 Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Specify 1 Yes 2 No P 1 🗆 Inpatient 2 ER/Outpatient 3 DOA After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: or Attending Injury 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

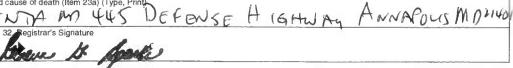
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 9 2008

Name and address of person who c

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State of Maryland / Department of Health and Mental Hygiene 118

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	/Medic Examin		4a Facility Name (If not institution, give	street end number)				4b. City, Town, or I	Location of Death	4c. County	of Death		
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	p He H	Š	11. Marital Status 1 ☐ Never Merried 2 ☑ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐		If Yes, s	pecify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Blac	ck, White, etc		
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Ē	ing P	Ë	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, De	y Year) 28t	o. Time of Injury	28c. Inju Wo		28d. Describe ho	ow injury occur	red		
sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2 No	00(1	too a to a mod & broad	D / /	Don't March of	
Division	or At fter of lirect in by	Certification:	4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, c. <i>(Specify)</i>	farm, street, fac	ory, office		28f. Location (St City or Town		er or Hurei r	toute Number,	
	oral Direct	ပ္	On Continu	-1-1			- 1						
	Host 24 ho Fund taly f	edical		relcian: To the best of iner: On the basis of	examination								
	25. Was case referred to medical examiner? 1						29c. License number 29d. Date					ev. Year)	
	5.25.8							8755		- 1	. /	-	
•	784										04/2	000	
	, 0.,		30. Name and address of person who c		eath (Item 23	a) (Type, Print)	8156	11 6/e	enn Ara	radon	, mn		
			31. Dete filed (Month, Day, Year)	0	er's Signature				•				
	Stat Registra	-	IAN A Q 20	100	e H	beart							

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
JAN 0 9 2008 Registrar

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAHIFAR

9801 Georgia Are Suit 4-41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of State Registrar	Maryland / Depa	artment of F		,0	ene g. No.			
	Physici	_	1. Decedent's Name (First, Middle, Last) Marie Gilchrist				2. Date of Death Month January		3. Time of Death 4		
	/Medical Examiner 4a. Facility Name (If not institution, give street and number) 4802 Ashford Drive					r Location of Death	2	4c. County of Dea	ath		
	Funeral Director		578-40-8457 1□M 2ĂF	. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/10/	Year) Co	thplace (State or Foreign buntry) efield, S.C.		
	/aryland f show ed at	or	Usual Residence of Decedent 10a. State	10c. City, Town or Lo	marlboro				10d. Inside City Limits X□Yes 2□No		
	r 28a-	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?		
	th with	al D	4802 Ashford Drive		207	772		U.S.A.			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 □ Yes 2 If Yes, Give Year or Date	X No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black			
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4	(Give life.	dent's Usual Occup kind of work done DO NOT use retire nemaker	oation during most of word d)	king	16b. Kind of Business/Industry Own Home			
land 2		To Be Co	17. Father's Name (First, Middle, Last) Wyatt Gilchrist			ne (First, Middle, M	rles				
			19a. Informant's Name/Relationship (Type. Print) Melvin Gilchrist/Son	T I	ng Address <i>(Street</i> ? Ashford			City or Town, State,	Zip Code) 20772		
Baltimore,		100	20a. Method of Disposition 1 □ MBurial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crea Washingt	osition (Name of matory or other pla	ce) • Cem• 01		Suitland,			
Balti		6 19	21. Signature of Funeral Service Licensee	1 22	2. Name and Addre H.S.Was 1925 Burro	ess of Facility shington oughs Ave	& Sons Co	o.,Inc. ashington,	D.C.20019		
	Physician /Medical Examiner	8 8	23a. Part1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition	used the death. Do not ent chiline. .ac Arrhythmi		ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death 1 Hour		
		L	Sequentially list conditions b. Sino	r as a consequence of): Atrial Node	Dysfunct:	ion			5 Years		
8760,	cate be executed physician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):								
687	death certifi e attending id for use as	edical	d					10			
O. Box		Physician/Me	in the past 12 months?	nt at time of death 5	□Ectopic pregnanc □ Other (specify) _	sy .		23d. Date of delivery Month Day Ye			
or Vital Records, P.	Se Ja	by	Part II. Other significant conditions contributing to deal Non Insulin Dependent Di	23e. Did tob	tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 □Unknown						
900	aw requir is been si 2 should t	Completed	Alzheimer's Disease	24a. Was ar	24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of						
Ä	The law ate has b page 2 sl	Com	Stroke				perforn	ned? death?			
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		041		th (Check only on	9)			
or	Phys this al dir	: To	1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ I ☐ In ☐ In ☐ In ☐ In ☐ In ☐ In ☐ In	patient 2 ER/Outpatier	111 3 1 0 0 A			esidence 6 Other (Specify) ne how injury occurred			
on	ding Ph th. : After th funeral	tion	1 ☑ Natural 5 ☐ Pending (Month 2 ☐ Accident investigation	, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No						
Division	or Atten after deat Director: in by the	Certification:		of injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town	(Street and Number or Rural Route Number, own, State)			
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner on the base and manner of the base and manner on the base and manner on the base and manner of the base and manner of the base and manner of the base	sis of examination and/or ir							
	vithi To t	2	29b. Signature and the of conflict	200	29c. Licens	se number 13026		9d. Date signed (Mor	,		
			JUNE 1	January 8,2008							
R	(1)		30. Name and accress of person who completed cause Stephen M. Seabron, M.D.			. # 209.W	ashingto:	n,D.C. 200	17		
	Sta			gistrar's Signature							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of or

			For State Registrar	State of IVI	arylanu /			te of L		na ivie	entai Hy	giene Reg. No	7000	0 1	605		
	1. Decedent's Name (First, Middle, Last) 2. Date of Death							eath	ath		of Death						
	Physician /Medical Sheila Galloway										Januar			9:31	A M		
	Examiner 4a. Facility Name (If not institution, give street and number)							, Town, or	Location of	Death		4c.	County of Deat	h			
	Holy Cross Hospital							Silver Spring			-	Montgomery					
81:	Funeral		5. Social Security Number 6. Se	x 7. Ag □ M 2 X F	ge (In yrs. last i	birthday) Yrs.	If Unde Months	Pr 1 Year Days	If Under 24 Hours	4 Hrs.	Date of Bi (Month, Di	rth a <i>y, Year)</i>	9. Birt Co	hplace (State untry)	or Foreign		
	Director		577-66-9029 58 11s. Usual Residence of Decedent						S	ept 17	7, 19	949 Was	hingto	n, DC			
	and w										10d. Inside (City Limits					
	Mary f sho	Ö	Marria and Mantage		T.Th. a. a.	.								1 X Yes	s 2 No		
	28a notif	rec	Maryland Montgome 10e. Street and Number	er y	⊥ Whea	LOII	10f. Z	ip Code				10g. Cit	izen of What Co	untry?			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	2307 Geogian Way	J.			2	0902				lini	ted Sta	tes			
	death	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	_		ispanic Origi	in? (Spec	cify Yes or Na Rican, etc.)		14. Race - Ame	rican Indian,			
9	after or ite		1 Never Married 2 Married	1 Yes 2 1 If Yes, Give				2 X No	Specify:	ruerton	iican, etc.)		Black, White	e, etc.			
21215-0036	ours irai", Exa	d by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:										Black			
5-0	72 h "natu dical	Completed	15. Decedent's Edu (Specify only highest grad	nt's Education 16a. December grade completed) (Give			dent's Usuai Occupation e kind of work done during most of working DO NOT use retired)				g	16b. Kind of Business/Industry					
121	vithin ne. than	m p	Elementary/Secondary (0-12)	College (1-4or !	5+)				0								
	Hygie ther ther nt, th		10 years 17. Father's Name (First, Middle, Last)			Hon	nemal	cer	18. Mother's	's Name	(First, Middle		Private				
Maryland	l 2 should be fi n and Mentai H i s marked o t raumatic ever	Be	Willie Grace	Edwards									<i></i>				
>	hould Me mark	မ	19a. Informant's Name/Relationship (7)		11	9b. Mailin	a Addres	ss (Street a			a Mae Suggs Gural Route Number, City or Town, State, Zip Code)						
Ma	nd 2 s ith ar 27 is 1 trau		Vernette Gallowa										MD 2074				
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition		20b. Place ceme						ate		ocation - City or				
Baltimore,			1 Durial 2 Cremation 3 In 4 Donation 5 Other (Specify,							Ian 1	/ 20	ng T	Landover	· MD			
Ħ	artra	ŀ	21. Signature of Funeral Service Licens	-	A. A.	22	2. Name a	and Addres	ss of Facility	Ste	wart]	Funei	ral Home	Inc.			
m	Dep Imp any	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, 1 4001 Benning Road, NE Washington, DC 20															
P			23a. Parti. Enter the disease, or composhock, or heart failure. List only of	lications that cause	d the death. D	1								Approxima	ate		
A)-	Physician		Immediate Cause (Final disease or condition			ic E	leart	and	Vesse	el Di	sease			Interval Be Onset and	Death		
X.	/Medical		Immediate Cause (Final disease or condition resulting in death) Arthrosclerotic Heart and Vessel Disease Due to (or as a consequence of):														
н	Examiner		Congestive Heart Failure														
	· ·	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
	ecute and trans	cam	that initiated events resulting in death) Last	C	a consequenc												
60,	be ex cian a			Due to (or as	a consequenc	e oi).											
68760,	tificate be executed g physician and as the burial-transit	edical		d													
	leath certifi attending I for use as		IF FEMALE:	23c. If yes, outcome	pf pregnancy								23d. Date of del	iven			
Вох	atter for u	ciar	in the past 12 months?	1 ☐Live birth 4☐Pregnant a	2 Fetal dea		Ectopic Other (s	pregnancy specify)					Month	Day Year			
0	that the dened by the a	Physician/N	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□Unknown			`										
О.	s that ned b							en in Part i.		23e. Did	obacco use contribute to the cause of death?			death?			
Records,	quires in sign	ed by									1 🗆	Yes 2	□ No 3 □ Pr	obably 4]Unknown		
တ္တ	aw requir s been si 2 should I	olete			~						24a. Was an 24b. Were autopsy fi				s available		
SOUND Seed of the part of the past 12 months? 1								death?									
Vital		BeC	25. Was case referred to medical						26. Place of	of Death	1 Yes (Check only	2 /Z No one)	1 103	2010			
-	dir dir	70 E	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ inpatio	ent 2 ER/0	Dutpatien	t 3 ∑ C	Othe	er: 4 🗆 Nurs	sing Hom	ne 5□Res	idence	6 □Other (Spe	cify)			
n or	ng ftel		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		. Time of injury		28c. Injury Work	y at	28	8d. Describe	d. Describe how injury occurred					
Sio		atic	2 Accident investigation M 1 Yes 2 No														
Division	I or Attenc after death Director: I in by the I	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inj building, et	ury - At home, tc. <i>(Specify)</i>	farm, str	eet, facto	ry, office		28	8f. Location (City or To		nd Number or Ru e)	ıral Route Nu	mber,		
	Hospital or 14 hours afte Funeral Dir tely filled in I																
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis on and manner st	of examination	ge, deatr and/or in	occurre vestigation	d at the tin on, in my o	ne, date and pinion, death	l place, a h occurre	nd due to the ed at the time	cause(s , date an) and manner as d place, and due	stated. to the cause	(s)		
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and marrier st	ateu.		25	9c. License	e number			29d. Da	te signed (Mont	h, Day, Year)			
	->-0		1	AC). (ind s	14		D1992	2/1			Ton	0	2009			
1	(2)	ŀ	30. Name and address of person who c	ompleted cause of c	leath (item 23a) (Type,		J = 77 Z	· "T			Jan	uary 8,	2008			
K			Lawrence Oufiero					ilver	Spri	ng,	MD 209	20					
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	W											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** E. Gibson 08:52 AM George 2008 January 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Cecil Union Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/27/1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠ M 2□ F 222-44-8528 50 Delaware Director Usual Residence of Decedent 10c, City, Town or Location 10a State 10d Inside City Limits 10b. County show at MD Cecil Elkton 1 XYes 2 ☐ No the Medical Examiner must be notified Director 28a-f 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 21921 USA 109 Milburn Street items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give 1 977~1978 Year or Dates! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married "natural", or if Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 11 injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Vera Gibson George E. Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Gibson / Brother permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 308 S. Claymont Street, Wilmington, DE Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition United Crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 01/09/08 Newark, DE 4 ☐ Donation 5 ☐ Other (Specify) Services 21. Signature of Euneral Service Licenses ²Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myocardial Infaction **Physician** 11 horr disease or condition resulting in death) Acute /Medical Due to (or as a consequence of): Examiner Empleady acute requiretury failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed Due to (or as a consequence of): Eyel COPDburial-trar attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for t in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò vifficile 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 10xrc 24a Was an megge olon has page 2 autopsy certificate Division or Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ne 1 Impatient P 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to Certification: Natural 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 4, 2008 D0055190 1 game 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Hospital 106 Bow Street, CIKton 40 21921 MD 32. Pegistrar's Signature 9 2008 31. Date filed (Month State Registrar

			For State of Maryla 1 - Registrer			riment of H		ientai Hy	_		2 0	01607
	,2		negistrar 1. Decedent's Name (First, Middle, Last)				Journ	2. Date of De		201	18	3. Time of Death
7	Physicia		Della Good	lman				Month Januar		ay 200	Year Q	8:45 A M
E.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	man		4b. City, Town, or	Januar		c. County of		0:43 A	
			7600 Huntsman Court			Clinto	n			Prince George's		
	Funeral		5. Social Security Number 6. Sex 7. Age (In)	rs. last birthd		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	rth ay, Yea			place (State or Foreign
	Director		240-88-8738 88 Usual Residence of Decedent	Yrs	·			Dec 22	, 19	919	No	th Carolin
	land w			City, Town or	r Loca	ation						10d. Inside City Limits
	Mary -f sho ied a	to	Maryland Prince George's	Clinto:	n							1¶Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. (Citizen of W	hat Cou	ntry?
	th with		7600 Huntsman Court			20735			Ur	nited	Stat	es
	ems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 1	13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)		14. Race		can Indian,
36	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No			□Yes 2∏ No	Specify:			Specify:		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	d be	3 ☑ Widowed 4 □ Divorced Year or Dates:	16a De	acado	ent's Usual Occup	ation		16h	Kind of Bus	B1a	
5	in 72 n "na Nedic	Completed	(Specify only highest grade completed)	- (G	ive k	ind of work done of NOT use retired	during most of work ()	ing	100.	Kind of Bu	311033/11	ddolly
212	with yiene.	lmo	Elementary/Secondary (0-12) College (1-4or 5+) 12 years	Far	mir	ng Larbo	rer			Priva	ite	
ğ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	, Maid			
<u>Ja</u>	2 should be filed and Mental Hygin is marked other aumatic event, the	ToE	Aaron Lowe				Louc	reaye I	Dick	tens		
a	2 sho and l is ma	ľ	19a. Informant's Name/Relationship (Type. Print)	1	_		and Number or Run		-			Code)
	and lealth m 27 her tr		Mildred Debrew - Daughter				n Court C					
O.	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		I Denial 2 Cremation 3 Premoval from State	_		tion (Name of atory or other plac	1	Date		Location - (-	
Baltimore,	t. Pa ntmen ntant: njury		4 Donation 5 ☐ Other (Specify)	ary's								l Neck, NC
Ba	permit. Departr Importa any inj		21. Sign, ture of Funeral Strvic Licens	MI			ss of Facility Ste					
è			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between									
7	Dharfalan		Onset and De									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Advanced Advanced Due to (or as a con-			EL S DISC	ease				-	6 Months
	Examiner		Alzheimer's Disease 7 years									7 years
	D =	ner	rause. Enter Underlying	lecusence of								
	ecuter Ind transi	Examiner	that initiated events c.									
9	be exician a		resulting in death) Last Due to (or as a con-	sequence or):								
68760	ifficate be executed g physician and as the burial-transit	edical	d									
_		/Me	IF FEMALE: 23c. If yes, outcome pf pre 23b. Was decedent pregnant							23d. Date	e of deliv	erv
Box	The law requires that the death cer to has been signed by the attendin bage 2 should be detached for use	Physician/M	in the past 12 months?			Ectopic pregnancy Other <i>(specify)</i>	'			Mor		Day Year
Р. О	t the	hys	9 ☐ Unknown					_				
Š	res that the de signed by the a be detached t	by P	Part II. Other significant conditions contributing to death but not		e uno	derlying cause give	en in Part I.	23e. Did	tobacc	o use contri	ibute to t	he cause of death?
Vital Records,	w require been sign	ted	Hypertension, Renal Insuffic	iency_				1 🗆	Yes	2[X]No	3☐ Pro	bably 4 □Unknown
မိ	law ras be	Completed						24a. Was	psy	p	Vere autorior to co	opsy findings available ompletion of cause of
<u> </u>		Con						perf 1∐ Yes	ormed 2 X		leath? □Yes	2 □ No
VII:	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?			Out	26. Place of Deat	h (Check only	one)			
	> 00	7°	1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury	2 ER/Outpa 28b. Tim			4 LI Nursing Ho	me 5 Res 28d. Describe				fy)
Division or	ding Ph h. After thi funeral	ion	1 □ Matural 5 □ Pending (Month, Day Yea			28c. Injur Worl	yen k? Yes 2 □ No	zou. Describe	11044 111	ijury occurre	B u	
12	or Attenerater death Director: in by the	fical	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number.)								al Route Number,	
ă		Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)									
	To the Hospital or A within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 ** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Discontinuous Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Discontinuous Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Discontinuous Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the H within 24 To the F complete	Medical	one) and manner stated.	11				Ted at the time				
	To Po	2	29). Signature and july of certifier	/ /		29c. License			29d. I	Date signed	l (Month	Day, Year)
)	6		the son hit	_/	/)9117		J	anuar	у 4,	2008
1	(4)		30. Name and addless of person who completed cause of death (Melvin D. Gerald, M.D. 7940				enarden, l	MD 2070	16			
	Sta	te	21 Date filed (Month Day Year) 32 Registrar's S	onature								
	Registr	ar	JAN 0 9 2008 Server &	grant								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Day Month William **Physician** Charles Hart 11:00 AM Jank 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death Examiner Hagerstown Washington Washington County Hospital 9. Birthplace (State or Foreign Country)
MD Social Security Number 217-28-6841 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) Oct 16 1929 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2 ☐ F 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Washington Clear Spring 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12367 Big Pool Rd 21722 U,S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No 1951If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Specify 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐No Specify: ģ 3 ₩ Widowed 4 Divorced 1953 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) county school filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) custodian permit. Pages 1 and 2 should be filed wn Department of Health and Mental Hygien. Important: if item 27 is marked other than any injury or other traumatin once. system 8th_grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John R. Hart Virgie A. Hart ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lucas 10879 Big Pool Rd. Big Pool, MD 21711 niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan.12, 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shanktown Cemetery Big Pool, MD 2008 21/Signature of Funeral Setvice Licensee ²² Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc P.O.BOX 310 Clear Spring, MD 21722 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectonic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 25. Was c. s: examirar: director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this nours after death.

neral Director: After this

filled in by the funeral d 27. Manner of Death
1 Natural
2 Accident 28a Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

Saltimore, Maryland 21215-0036

Medical Certification: To within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion death occurred. 29a, Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier on Coult 32. Redistrar's Signature State JAN 1 1 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

determined

4 Homicide

			For State Registrar	State of M	larylan	-	artmen				-	giene Reg. No	2000	3	01609
	81		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea				3. Time of Death
	Physici /Medio Examir	cal	CLYDE KING H 4a. Facility Name (If not institution, giv	UNTSBERRY e street and number	·)		4b. City,	Town, or	Location of	of Death	JANUARY	7 9			3:02 A ^M
1	Lxaiiiii	iei	WILLIAMSPORT NUR				· .		IAMSE				WASH		CON
	Funeral		5. Social Security Number 6. S	6ex 7. A	ge (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of Birt (Month, Da	h V Year)			e (State or Foreign
	Director		214-09-6/56	M 2□F	102	Yrs.	Morturo	Juys	710010		APRIL 8				LAND
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d	. Inside City Limits
	Mary fed	ŏ	MARYLAND WASHI	MCTONT				LIT	LLIAM	⁄/CD∩I	OΨ				1 ☑ Yes 2 ☐ No
	h the	Director	10e. Street and Number	NGTOIN	1		10f. Zip		יייי דרוד	IOI OI		10g. Cit	tizen of What	Country	?
	th wit		154 NORTH ARTIZA	N_STREET				21	795				U.S.	Α.	
	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show dicel Exercities from the profiled at	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13. \	Was Deced	lent of Hi	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	_		1□Yes :		Specify:				Specify:	тлтт	or to
٥ ڳ	ture!		15. Decedent's E			16a. Deced	dent's Usua	I Decupa	ition	-		16b. K	and of Busine	WHI ss/Indus	
215	nin 72	piet	(Specify only highest gra Elementary/Secondary (0-12)		54)	(Give	kind of wor DO NOT us	rk done d	uring mos	t of work	ing	, , , , ,			,
21	giene giene	Completed	6	College (1-40)	3+/		MAC	HINI	ST			AIR	CRAFT	MANU	JFACTURING
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last,								e (First, Middle,				
yla	Meni	ဥ	HENRY EARL HUNTZ								VIOLA WI				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itema 23a or 28a-f show with injury or other treumatic event, the Medical Evan it are must be notified at ance.		19a. Informant's Name/Relationship (BETTY J. MAHANEY/				•				al Route Numbe FAIRPLA				21733
	is 1 and 2 of Health a item 27 le		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of			Date		ocation - City		
Baltimore,	ages ant of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specific	Removal from State	, 0	semetery, cren	natory or o	ther place	- 1	1/1/	7/2008		-		MARYLAND
Ė	artme ortan injur		21. Sig lature of Fineral Service Los		IC TIA		. Name an			_	7606 01				
ä	Depa Impo eny i		Down M/1	w- Paul	M. D	ean B	AST F	UNER	AL HO	ME	Boonsbo				21713
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the deat	h. Do not ent	er the mod	e of dying	, such as	cardiac				A	pproximate iterval Between
-	Physician		Immediate Cause (Final disease or condition	. VIRA		PNEL	EM O A	LIA							INSEL and Death
	/Medical		resulting in death)	Due to (or as				0111							WECK.
	Examiner		Sequentially list conditions,	b		Uranto-mores									
	bed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Qualto (or as	a conseq	uanea ot):									
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9	tificating phy as the	ledicai		. d.										1	No. of the same
Вох	eath certific attending p	J/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pr	emancy					23d. Date of	delivery	
	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (sp						Month	Da	ay Year
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ā	in: Ti ificate or. pa		25. Was case referred to medical						20 81	-45		2 🗷 No	1 U Y	es 2[□ No
5	ysicie s cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpati	ent 2 🗆	ER/Outpatien	t 3 DO	A Othe			h <i>(Ch</i> ec <i>k only o</i> me 5 ☐ Resid		6 □Other /S	necify)	
5	ng Ph ter th		27. Manner of Death	28a. Date of Inj	ury	28b. Time of Injury		8c. Injury Work		3	28d. Describe I			p. c, /	
Ö	endir sath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investigation	1		,	М		/es 2 □	No					
Division of Vital Records,	l or Att after de Direct	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place of in	iury - At ho tc. (Specif	ome, farm, stri	eet, factory	, office			28f. Location (S City or Tox			Rural F	loute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		00- C-45- 47- C-47- B												
	Hospital	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysicien: To the best niner: On the basis of and manner st	of examina	tion and/or inv	estigation,	in my op	e, date an inion, dea	id place, ith occur	and due to the ored at the time,	date and) and manner d place, and c	as state fue to th	ed. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c	. License	number			29d. Da	te signed (Mo	onth, Da	y, Year)
	> - 0		1 Hohamo	M			7	137	5700)		TON	WARY	9	7000
			30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)		,,-0			ט וו שנ.	ve i e i	1.5	2000
5	H-4		TED EN HOWE	154	N. 1	ARTIZA	N 5	T, L	NILL	AM	SPORT.	M	VD -	217	95
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	iture	hade	,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MARGARET T. HUGHES 930 5 January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Hospita Easton Memorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
NOV 26 1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗶 F 88 PA Director 175-16-4866 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT ST., #1122 21601 USA Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or iten Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHTTE 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. n 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 PUBLIC EDUCATION CAFETERIA MANAGER or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IMRE TOROK ROSE RACZ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health PO BOX 340, BOZMAN, MD 21612 WILLIAM HUGHES/SON Baltimore, Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department or Important: If any Injury or MANSION MEMORIAL PARK 1/15/2008 ELLENTON, FLORIDA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST, EASTON, MD 21601 Losph Ostrouski C.F.S.A. M. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASPIRATION PNEUMONIA Immediate Cause (Final disease or condition Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE Sequentiary first commons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan autopsy performed? res 2 No 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔽 No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 24 | To the within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier phutsitsu D0059437 6 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 219 S JOHN BOTSIS M.D. WASHINGTON ST. EASTON, MD 21601 State Registrar

DHMH 17 Rev 1/2001

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Baltimore. Maryland 21215-0036

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		•	1 - State Registrar		Ce	rtificate of	Death		Reg. No	008	01611	-
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			MICHAEL R. H	ARRISON							9:30AM M	1
			, ,)	4b. City, Town, o	r Location of Death		4c. C	county of Death		
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Reg. No. C							TALBOT	place (State or Foreign				
							ay, Year)	Cour	nace (State of Poreign ntry) YLAND	11		
2					48			JUNE 9	,1939	PIAK.	LLAND	_
	ylanc now		10a, State 10b. County		10c. City, Town or Lo	cation				1	Od. Inside City Limits	
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State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Mode), Last) Physician Modelia Examine TALBOT HOSPICE HOUSE Function Director 1. Decedent's Name (First, Mode), Last) MICHAEL R. HARRISON 4. Col. TALBOT HOSPICE HOUSE Function Director 1. Decedent's Name (First, Mode), Last) MICHAEL R. HARRISON 4. Col. TALBOT HOSPICE HOUSE Function Director 1. Decedent's Name (First, Mode), Last) Modelia 1. Decedent's Name (First, Model), Last) Modelia	Black, White,											
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alti	rmit. spartn porta y Inju		21. Signature of Funeral Service	Licensee	. 172	2. Name and Addre	ess of Facility	N & NRW	NAM F	IINERAT.	HOME PA	
<u>m</u>	99 1 6 9			· Ostevili	CF. >2	<u>00 S. ĤAI</u>	RRISON ST	EASTON	, MD			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not en line.	ter the mode of dyli	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
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			resulting in doubt)	Due to (or a	s a consequence of):	7						
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	he de the a	ysic	1 ☐ Yes 2 ☐ No		at time of death 5	_ Other (specify) _						
Δ.	that t ed by detac		Part II. Other significant condition	ons contributing to death	but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?	
sp.	uires sign lid be	d b						1	Yes 2□	No 3 Pro	bably 4 Unknown	'n
Ö	w rec s beer s shou	lete								24b. Were auto	opsy findings available	le
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<u>r</u> <	hyslc nis ce I direc	0		Hospital: 1 ☐ Inpa	tient 2 ☐ ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗆 Nursing H	lome 5□Re	sidence 6	X Other (Speci	HOSPICE	3_
п		100			jury 28b. Time o lay Year) Injury			28d. Describe	how injury	occurred		
sio	tendi leath. tor: A	cati	2 ☐ Accident investig	gation	alum. At home form of		Yes 2 □ No	DOS Lagation	(Ctroot and	Alumber or Bur	ral Bauta Alumbar	
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	spital ours a neral filled		29a. Certifier 1 Certifvir	ng Physician: To	st of my knowledge, dea	h occurred at the t	ime, date and place	, and due to th	e cause(s)	and manner as	stated.	
	e Hos e Fur letely	dica	(Check only 2 dical	Examiner: O asis	of examination and/or in							
	within To th comp		29b. Signature and title of certifie	1/10		29c. Licens	se number		29d. Date	signed (Month,	. Day, Year)	
				11/		DI	00271	0	1	-9-6	28	
			30. Name and address of person	who completed cause of	15-16 (Type	Print)	1 10 000				nether =	
		1	DAVID C. HAL	VERSON_M.D.	8221 TEAL	DRIVE, SU	JITE 302,	EASTON	, MD	21601		

State Registrar

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aaco	o hltl	n g	18 per fd State of Maryland / Dep lept 01/15/08 dlw State of Maryland / Dep l- State Registrar Co	rtificate of Death	Re	eg. No 2008	01612
. 6.		-	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
* 5	Physicia /Medic	_	John W. Hensley		1/4/	/2008	6:20 Am
	Examin	and the	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			1245 Ellicott Ave. 5. Social Security Number	Churchton if Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arı	thplace (State or Foreign
	Funeral Director		216-76-1964 1⊠M 2□F 50 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 3/18/19	957 Ma	aryland
3	2 ,		Usual Residence of Decedent 10a State 10b County 10c. City, Town or I	ocation			10d. Inside City Limits
3	show ed at	Į.	MD Anne Arundel 10c. City, Town or U				1 □Yes ¾√xNo
4	me notification	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	puntry?
4	3a or st be		1245 Ellicott Ave.	20733		USA	
100	oean oms 2 or mus	Funeral		. Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame Black, Whit	
36	or ite	by Fu	1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	•		nite
21215-0036	De lied within 7.2 hours arer death with the Marital Hygiene. do other than "natural", or items 23a or 28a-f shevent, the Marital Examiner must be notifiled.			edent's Usual Occupation		16b. Kind of Business	/Industry
215	in "na in "na Medic	plet	(Specify only highest grade completed) (Giv Eiementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	king		
212	grene grene er tha the	Completed		ner		Construct	ion
ב ב	d oth	Be	17. Father's Name (First, Middle, Last) James M. Hensley			Maiden Surname) Lillian	Footo
-yla	z should be lifed within 7.2 hours after death with the maryland, and Mental Hygiene. I so marked other than "natural", or items 23a or 28a-f show 'aumatic event, the Macical Examiner must be notified at	2	<u> </u>				
Maryland	s I and 2 should f Health and Mer Item 27 Is marke other traumatic			ling Address (Street and Number or Ru Ellicott Ave. Cl	nurchton		
	other tra			position (Name of ematory or other place)		20c. Location - City or	
Baltimore,			1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Cr	!	/2008	Baltimore	, MD
alti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ha	desty Fu	ineral Home	
<u> </u>	6 4 5 6 6			0 0		, MD 21401	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arr	est,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	unce			2 minths
	Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	ransit	Examiner	that initiated events c				
760,	oe exe cia n a curial-	al Ex	Due to (or as a consequence of):				
687	To the Hospital or Attending Prhysician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dic	d				
Вох (certifi nding use at	Physician/Medic	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	elivery
Ď.	death e atte	icia	in the past 12 months? 1 Days 2 DNo 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	ar the de by the stached	hys	9 □ Unknown		00. 5:11		
'n	res than igned to be det	þ	Part ii. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute t es 2 □ No 3 □ P	
orc	w require been sig should b	eted					
Rec	ne law has t ge 2 s	Completed			24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of
<u>a</u>	sician: The certificate harector, page		25. Was case referred to medical	26 Place of Dea	1 Yes ath (Check only or		s 22 No
or Vital Records,	hysicia this cert al direct	To Be	examiner? 1 Yes Popital: 1 Inpatient 2 ER/Outpati	Othor		ence 6 □Other (Spe	ecify)
0	aing Pn n. After th funeral		27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time Injury		28d. Describe h	ow injury occurred	
Division	eath. tor: A the fu	Certification:	2 Accident investigation	M 1 Yes 2 No	OOK Leasties (C	the of and Musebones E	Rum I Barrio Mumban
ivi i	or At after d Direct in by	rtifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	erreet, ractory, onice	City or Tow	treet and Number or Fi n, State)	turai Houte Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, de				
h.	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occi	urred at the time, o	date and place, and du	e to the cause(s)
_	T T T T T T T T T T T T T T T T T T T	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	
•	Can.	7	- Heronan	W3 1930		21-07-2	
1	7/1/A.		30. Name and address of person who completed cause of death (Item 23a) (Typ HEATHLY D MANNULL 106 23 C.	Greene St. Ba	Himure	2 Mb 21	201
1	Sta		30. Name and address of person who completed cause of death (Item 23a) (Typ Heather D Mannuel Ms 23c). 31. Date filed (Month, Day, Year) JAN 0 8 2008 32 degistrar's Signature	South &			
	Regist	ar	JAMES O LOSS JOHNSON				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Table 1 Name (First, Modele, Last) Vincent T. Holms Summer (First, Modele, Suiden Summe) Clara Hamilton 19a. Informan's Name (First, Modele, Last) Vincent T. Holms 19a. Informan's Name (First, Modele, Last) Vincent T. Holms 19a. Informan's Name (First, Modele, Last) Clara J. Holms 19a. Informan's Name (First, Modele, Last) Clara J. Holms 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informan's Name (First, Modele, Last) Clara J. Holms 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address of Facility Treetmen ##1431; District Heights, MD 20747 20a. Matter of Date of Code, State of Participation of Code,														
P	hysici	an	1. Decedent's Name (First, Middle,						-		2. Date of De	ath	8 Year		
			4a. Facility Name (If not institution,	give street and nun	nber)							4c. Coun	ty of Death		
			5. Sociaf Security Number 6	. Sex			If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da 10/04/19		9. Birth	place (State or F	Foreign
Ð					10c. Cit	y, Town or Lo	cation							10d. fnside City	
ы Мал	Ba-fath	ctor			Di	strict I						2:.		- 41	! No
with th	l Le n	Dire		apt#1431								_	What Cou	ntry?	
50 s after death	, or items 2;		11. Marital Status 1 Never Married 2 Married	12. Was Dece Armed For 1 Yes ff Yes, Giv	rces? 2 X No e					gin? (Spe	ecify Yes or No Rican, etc.)	BI	ack, White,	, etc.	
Z I Z I 3-UUSO d within 72 hours af giene.	n *natural		15. Decedent's (Specify only highest	Education grade completed)		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us	Il Occupa rk done d se retired,	ation <i>luring</i> mos	t of worki	ng	16b. Kind of	Business/Ir	ndustry	
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yland ould be file Mental Hy	arked oth	Be		ist)									ıme)		
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Dermit. Pages Department of	Importar any injur once.				0	22	. Name an	d Addres	s of Facilit						
/Me Exa	edical miner	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Undertying Cause (Disease or injury that initiated events	a. Due to (b. Due to (c. Due to (or as a conseq	uence of):						rrest,		Onset and De	ath
. 0	y the attending priched for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊡Live b 4⊡Pregn	irth 2 ☐ Feta ant at time of d	Ideath 3									ar
quires that	n signed b	by	Part II, Other significant condition Hepotitis C	s contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I			-/			
I RECOLDS, The law requires t	ate has bee page 2 shoi	Complete									auto perfe	psy ormed?	prior to death?	ompletion of cau	vailable use of
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on or ding Phys	After this funeral di	F-	27. Manner of Death 1 Natural 5 Pending	28a. Date of	of fnjury	28b. Time of	2	8c. Injury Work	at					ny)	
UIVISION al or Attending after death.	f Directors d in by the	ertifica	3 Suicide 6 Could no	t be 28e. Place	of fnjury - At heng, etc. (Specif	ome, farm, str y)	eet, factory	, office					nber or Rui	ral Route Numbe	91,
• Hospita	R Funera		(Check only 2 Medical Ex	caminer: On the ba	asis of examina	wledge, death	occurred vestigation,	at the tim	ne, date an pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) and r date and place	nanner as e, and due	stated. to the cause(s)	
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16	7		30. Name and address of person w		Basil	CT		٤ 20	io L	LOLFA	0 140				
- 8	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 2008		egistrar's Signa	ature de la constante de la co) ,				

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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		For	State of Ma	arylan	_	artment of H		Mental Hy	giene		
		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	2009	01516
Physicia	an	1. Decedent's Name (First, Middle,	Last)	0		77		2. Date of De Month	Day		3Time of Death
/Medic		Alice 4a. Facility Name (If not institution,	give street and number)	С		Hense	On r Location of Deat	<u>Januar</u>		, 2008 County of Deat	9:30 a [™]
Examin	er	2004 Amberlead	-	ot r	г– 3	Waldo			- 1	harles	
Funeral			6. Sex 7. Ag		last birthday)			8. Date of Bir	th	9. Birt	hplace (State or Foreign
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land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
Mary I-f sho fied a	to	Maryland Charl	es		Wal	dorf					1X1Yes 2□No
th the or 28a e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	ountry?
ath wi	ral	2004 Amberleaf				20				USA	
er de	Funeral	11. Marital Status 1 ☐ Never Married 2☐ Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 📉	Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 1	 Race - Ame Black, Whit 	
urs af al", or xami	ρ	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:	140		1 ☐ Yes 2 🔀 No	Specify:			Specify: B1	ack
72 hor	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occup	nation	rkina	16b. Kir	nd of Business/	Industry
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illed w Hygie ther t		1 2 17. Father's Name (<i>First, Middle, L</i>	ast)		1	Homemal		ne (First, Middle,		omesti	.C
should be filed within 72 hours after death with the Maryland Mandal Hygjene. In arked other than "natural", or items 23a or 28a-f show amatic event, the Medical Examiner must be notified at	To Be	Joseph	2017	F	lenso	n	Hester	tio (i not, imadio)	maracri		ord
shou ind M mar	۲	19a. Informant's Name/Relationshi	p (Type. Print)					ural Route Numb	er, City or	r Town, State, 2	Zip Code) 21117
and 2 ealth a n 27 is		Gwendolyn Hens	on/Daught	er	17 Ma	atinee (Ct. Apt	.E Owin	igs l	Mills,	Maryland
Pages 1 nent of He int: If Iten iny or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Loc	cation - City or	Town, State
t. Pag tmen tant:		4 □ Donation 5 □ Other (Sp.	ecify)		tropo	litan	1/8	3/08	Alex	andri	a,Virginia
permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit, Pages 1 and 2 should be filed within 72 hours after death with Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	isee	1.0		2. Name and Addre					
C 30 C 2		23a. Part1. Enter the disease, or	plications that cause	1 S d the deat						, mar yı	and 20608 Approximate
Physician		shock, or heart failure. List o	nly one cause on each li	ne.		1 1	/				Interval Between Onset and Death
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The law requires that the death certificate bate has been signed by the attending physicoage 2 should be detached for use as the b	Physician/Medical	IF FEMALE:									
attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	al death 3[□Ectopic pregnanc	у		2	23d. Date of de Month	lîvery Day Year
the de	ıysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□Unknown	t time or c	ieain 51	Other (specify) _					
s that ned b	by Pt	Part II. Other significant condition	s contributing to death b	ut not res	ulting in the u	ınderlying cause gi	en in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
equire en sig ould b								1 🗆	Yes 25	No 3□P	robably 4 Unknown
2 2 8	Completed							24a. Was		24b. Were at	utopsy findings available completion of cause of
r: The								perfo 1□ Yes	ormed? 2⊠ No	death? 1 ☐ Yes	2 No
siciar certif irecto) Be	25. Was case referred to medical examiner? 1√□ Yes 2□ No	Hospital: 1 ☐ Inpatie	ont 2	LEB/Outpatio	nt 3□ DOA Ott	or.	ath (Check only			
g Phy er this	n: To	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	III 0 DOX	4 Li Nursing i	Home 5 Resi 28d. Describe			icity)
ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	ly rear)	Injury		Yes 2 No				
or Att fter de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At he c. <i>(Specil</i>	ome, farm, st fy)	reet, factory, office		28f. Location (City or To			ural Route Number,
ours a		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my kno	owledge, dea	th occurred at the t	me date and place	e and due to the	cause(s)	and manner a	s stated
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examina	ation and/or in	nvestigation, in my	opinion, death occ	urred at the time,	date and	place, and du	e to the cause(s)
To the within To the Comp	Me	29b. Signature and title of certifier	Tagouri	MO		29c. Licens			29d. Dat	e signed (Mon	th, Day, Year)
		Yania M.					55088	5	1/4	108	
Seil		30. Name and address of person w	rho completed cause of c	death (Item	n 23a) (Type	Print)	0646				
Sta	te	31. Date filed (Month, Day, Year)	9 2008 32. Figistr	rar's Signa	ature	1					
Registr		JAN 0	9 2008	w.	S. A.	parke					

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State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Horne-11 Yea Month **Physician** MADELINE 1436 3 2008 4c. County of Death JAN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NNAPOLIS trundel Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1/10/1933 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Days Washington, DC 214-30-0914 74 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r than "natural, or items 23a or 28a-f sho the Medical Evantiner roust be notified at 1 ☐ Yes 2 X No Anne Arundel Harwood Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20776 IISA 4658 S. Polling House Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education
(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kitchen Manager Southern High School 12th important: If item 27 is marked other any Injury or other training once. marked other 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Haller Herbert Ringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4658 S. Polling House Rd., Harwood, MD 20776 Ralph I. Horrell/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/9/08 Lothian, Maryland Mt. Zion UMC Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral Service Licensee 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** HEART DISCASE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? signed by the a lid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown CANDINOMA, COLON ģ 24b. Were autopsy findings available prior to completion of cause of death? as been signal 2 should b 24a. Was an autopsy performed? Completed has page 1 ☐ Yes 2 No 1 TYes 2 No this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpetient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Hospital or Attending 24 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide within 24 hours a To the Funerel L 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D06054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 95 America Ct. MD 0 egistrar's Signature State 7 2008 JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:32 P™ JANUARY 2008 **JOHNSON** SHIRLEY LOUISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON SHARPSBURG 2048 DARGAN ROAD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🔀 F PRIL 30, 1935 MARYLAND Director 218-30-7680 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director SHARPSBURG MARYLAND WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 2210 DARGAN ROAD 21782 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married r than "natural", or in altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 CLOTHING MANUFACTURE SEAMSTRESS traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBERT AUGUST LOHMAN GOLDIE SHOOP ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trainonce. 2048 DARGAN ROAD, SHARPSBURG, MARYLAND BURTON E. JOHNSON JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t of h Pages ' 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/11/2008 SAMPLES MANOR CEM. SHARPSBURG, MARYLAND 22. Name and Address of Facility 21. Signature Foneral Service Lice 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Morth **Physician** RECORDENT CEREBURE VASCULAR SCEIDEN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): physician as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 ✓ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an s certificate has t irector, page 2 s autopsy performe 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Son's home Certification: To 2 No 1 TYes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Box 68760. P.O. Division or Vital Records, To the Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fi within 24 hours a

To the Funeral (
completely filled

3H-10

State

Ronald E. Miller 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only

6 Could not be determined

MD

1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21771 4 Culwell Drive, Mt. Airy, Maryland M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2, 2008 **Physician** Doris O. Johns 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Funeral 1 □ M 2 🗙 F Days 28, Y 75 438-50-5357 Louisiana Director Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Maryland Annapolis r 28a-f sh 1 ☐ Yes 2XXNo Director the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or in yor other traumatic event, the Medical Examiner must be not not the traumatic event. U.S.A. 1024 Jigger Court 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Counselor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Vardeman O'Quinn Ellen Claire Holtzworth 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Robbert/attorney 2661 Riva Road, #410, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages ' Important: If it any Injury or o once, 1 ☐ Burial

☐ Removal from State Baltimore Crematory 1/7/2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 50 u 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 years ASVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Hypertension 20 years Due to (or as a consequence of): physician ar P.O. Box 68760. Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate ha death? 2□ No 1□ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical uneral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 3 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Dir 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0059310 January 2, 2008 0-01 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, Suite 223 Laurel, Maryland Bruce Neckritz, D.O. 32. egistrar's Signature 31. Date filed (Month, Day, Year) JAN 0 7 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ralph 2223 M Jones 200 8 /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Eacility Name (If not institution, give street and number) **Examiner** Dicomica Kegionas Medicin Center satisbury If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months 1 2 M 2 □ F Director 216-38-9611 66 31, 1941 Oct. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State show r 28a-f shov notified at 1X Yes 2 □ No Director Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 609 Terrapin Lane 21804 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 □ No 1962 – If Yes, Give Year or Dates: 1965 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Ś 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education alth and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Jones Josephine Domin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Jones- Wife permit. Pages 1 a.
Department of Hea.
Important: If Item 2.
any injury or 609 Terrapin Lane Salisbury, MD 21804 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva 1/8/2008 Delmar, Delaware 22. Name and Address of Facility 21. Signature of Fuperal Service Licerisee Bounds Funeral Home 705 E Main St. Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LARDIOMYULATHY LONG ESTIVE /Medical Due to (or as a consequence of): Examiner LOBONARY Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ASE VD ician and burial-trans Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ FAILURE; 2 No 3 Probably 4 XUnknown HYPER KALEMIN Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No 2 X ER/Outpatient 3 □ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

To the Hospi within 24 hou To the Funer

State Registrar Dennis Chodniela, mb 100 & Carroll St.

31. Date filed (Month, Day, Year)

32. Regionar's Signature

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Day, Year) 32. Registrar's Signature JAN 0 8 2008

aigrar's Signature

Salisbury,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🔒 🗎 State Amended items 17&18,01/11/2008 Gertificate of Death Registrar WCHD, SLU 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sophia 2008 3:40 PM Α. Jones 01 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Ecaminer Wicomica Salisbury 'castal Hospice at the lake If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Months Hours 1 □ M 2 🕅 F 79 213-24-0171 5/26/1928 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Salisbury Wicomico 10g. Citizen of What Country? 10e. Street and Number 21804 USA 804 College Lane · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 <u>registered nurse</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Almedia Hall Almedia Thompson Marvin Jones Marvin N. Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 804 College Lane, Salisbury, MD 21804 Edward Jones/husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO Memorial 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/10/08 Salisbury, MD 4 Donation 5 Other (Specify) Park 21. Signat. 22 Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIUR PULMONAR Y DRSRASE **Physician** CHRONIC /Medical Due to (or as a consequence of): Examiner BREAS CARCINOWA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the IF FEMALE: nse. 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9☐Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be (26. Place of Death Check onl one funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 mpatient 2**X**No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Hospital or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide n 24 hours after de le Funeral Directo letely filled in by t 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ 00058410 30. Name an orderess of person who completed cause of death (Item 23a) (Type, Print) P.O BOX 1733 SAVISBURY WD 21802 WARIS GHUMM COASTAL State 2008 Registrar

ophia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_		For State Registrar		Otate of Wit	ar yrarre		rtificat					Reg. No	0000	01	620
	Physicia	an	1. Decedent's Name (First Robert) bert	John	son				2.	Date of De Month	Da	year Year		e of Death
	/Medic Examin		4a. Facility Name (If not i			00111		4b. City,	Town, or	Location	of Death	Knivar	Ψ	c. County of Deat		
	Exami	CI	PENINSULA	REGIONA	L MEDICAL	CENT	ER	SA	LISB	URY				WICOMIC	co	
75	Funeral		5. Social Security Number	r 6. Se		e (In yrs. la	ast birthday)		1 Year	If Under	24 Hrs. 8. Min.	Date of Bir (Month, Da	th ıy, Year	0.00		te or Foreign
F	Director		220-26-2853		AM ZUF	78	Yrs.				2	2/26/1			yland	
	and w		Usual Residence of Dece 10a. State 10b.	County		10c. City,	, Town or Lo	ocation							10d. Inside	City Limits
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-	with the Marylan a or 28a-f show be notified at	irec	10e. Street and Number		-			10f. Zip	Code				10g. Ci	tizen of What Co	untry?	
)	th wit 23a o 1st be	Funeral Director	4842 Camp	ground	Rd			2	1822					USA		
3	r dea tems er m	nuel	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S	3. 13.	Was Dece If Yes, spe	dent of His	spanic O n, Mexica	rigin? (Specif an, Puerto Ric	y Yes or No can, etc.))-	 Race - Ame Black, White 		3
36	's afte	by Fi	1 ☐ Never Married : 3 🕱 Widowed 4 ☐ I		1 ☐ Yes 2 📆 i If Yes, Give Year or Dates:	No		1 ☐ Yes	2 X No	Specify	<i>r</i> :			Specify: W	hite	
John 5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	ted t	15. [l Decedent's Edu	ucation		16a. Dece	dent's Usu	al Occupa	ation			16b. h	Kind of Business/	Industry	
	be filed within 72 ho tal Hygiene. d other than "natul event, the Medical	Completed		ly highest grad (0-12)	le completed) College (1-4or 5	5+)	(Give life.	DO NOT u	rk done d se retired,	luring mo)	st of working					_
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As Rob Marvland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manault aumatic event, the Manault aumatic event.	Be	17. Father's Name (First, Arch John								er's Name <i>(F</i> la Hit		, maidei	n Surname)		
Z 2	d 2 should In and Men 7 is marketraumatic	ြ	19a, Informant's Name/F		voe. Print)		19b. Maili	na Address	(Street a				er, Citv	or Town, State, 2	Zip Code)	
$\frac{1}{2}$	5 £ 1 ±		Dorothy A			er	1	-	•					21875		
Z Se	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	on o T		20b. Pla	ace of Disp emetery, cre	osition (Na	me of other place	e)	Dat	е	20c. L	ocation - City or	Town, State	•
imo	Page nent c ant: if		1 🔀 Burial 2 □ Cre 4 □ Donation 5 □				oam C				1/13/	08	Si	loam, MI)	
<i>390-26-285</i> 3 ■ Baltimore, Ma	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other		21 Signature of Funeral	Service Licens	see		2	2. Name a Holl c	nd Addres	s of Faci Fune	ral Ho	me Pro	ofes	sional A	Associ	ation
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9 X	h certifi ending use as		IF FEMALE:	un ont	23c. If yes, outcome									23d. Date of de	iverv	
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ō	Phys er this eral di	. To	1 ☐ Yes 2 No 27. Manner of Death	1	28a. Date of Inju	ury	28b. Time		28c. Injun Work	4 ⊔ №				6 □Other (Speury occurred	cify)	
<u>o</u>	nding F th. r: After e funer	tion	1 Natural 5 2 ☐ Accident	Pending investigation	(Month, Da	y Year)	Injury	М		<br Yes 2 [□No					
vis Si	i or Attend after death Director: ,	tifica	3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e. Place of inj	jury - At hor tc. (Specify	me, farm, s	reet, factor	y, office		28	f. Location ((Street a	and Number or R te)	ural Route l	Vumber,
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	To the within 2 To the соттре	Med	29b, Signature and title	of cortifler	and manner st	ateu.		29	c. License	e number			29d. D	ate signed (Mon	th, Day, Yea	ar)
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	374		30. Name and address of	of person who	completed cause of c	death (Item	23a) (Type		- 0 (/						
	J		Tom Swier	Kosz			54.5	SAlish	ary	me	1 218	01				
.4	Sta		31. Date filed (Month, P	N 114 21	008 32. Pregisti	rar's Signat	ture	San Ale	ر	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FLEN **Physician** NNE KUCENA 0953 OL 2008 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 171-12-9402 87 8/16/1920 PA Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is marked other than "---10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Anne Arundel Millersville 1 ☐ Yes 🛣 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 60 Linda Lane 21108 Be Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo White Specify Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education t of Health and Mental Hygie If Item 27 is marked other to or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kajetan Majher Maria Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Linda Lane Millersville, MD Charles Joseph Kucera Spouse 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MXBurial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any njury or once. 4 □ Donation 5 □ Other (Specify) Arlington National 1/22/2008 Arlington, VA 22. Name and Address of FacilityHardesty Funeral Home, P.A. rvice Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AG15 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Lan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 20 No 1 Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Design 2 ER/Outpatient 3□ DOA this 28a. Pate of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 (Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 🖺 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by • Funeral C Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2

State Registrar 29b. Signature and title of partifie

31. Date filed (Month

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Dav. Year)

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

JAN 1 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:29P M /Medical ounty of Dea 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Jashun lumoro If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7, Age (In yrs. last birthday) **Funeral** Months Days Year) 960 Country) Maryland 1 □ M 2 🔽 F 47 213-76-5996 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show la or 28a-f sh t be notified a 1 ☐ Yes 2√∑ No Maryland Anne Arundel Severn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must b 8385 Pioneer Dr. 21144 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 'natural', or Iter dical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 X Divorced 27 is marked other than "nature traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Annapolis Police Elementary/Secondary (0-12) College (1-4or 5+) 12th Department Secretary permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygh. Important: If item 2.7 is marked any Injury or other *** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Kasey Sr Lillian A. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vernessa J. Belon(Sister) 822 N. Broadway Baltimore, Md. 21205 Date 20c. Location - City or Town, State 20a. Method of Disposition 20ba Place of Disposition (Name of Dec C K 1X Burial 2 ☐ Cremation 3 ☐ Removal from State UMC Cemetery 1-9-08 Annapolis, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee WinNameRed & sess of Eacityons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Jarry B. Leese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) -3-08 **Physician** 10 car /Medical Due to (or s consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Due to (or as a consequence of): burialphysician a Box 68760. Physician/Medical as attending IF FEMALE: nse s 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year ρ 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 3 robably 4 □Unknown 1 Tes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 R/Outpatient 3 DOA 2 1 🗌 Yes 1 🗌 Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. ■ Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signeture and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Cla Ta 31. Date filed (Month, Day, Year) State JAN 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Maryland	/ Depa	artment of H	ealth and	Mental Hy	giene nna	01621
			1 - State Registrar		Cer	tificate of L	Death		Reg. No.	01023
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	Day Year	3. Time of Death
	/Medic		Annie W.	Kenney				Januar	*	8:10 A M
-	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		tn	4c. County of Dea	George's
12	Funeral		Prince George's F 5. Social Security Number 6. Se		st birthday)	Chever1	If Under 24 Hrs			hplace (State or Foreign
30	Director		578-58-2209	□M 2½2F 81	Yrs.	Months Days	Hours Min	April 2	2, 1926 A1	abama
	pud *		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
	Maryli f sho	5								1 XYes 2 ☐ No
	r 28a-	Director	District of Col 10e. Street and Number	umbla wa	ashin	10f. Zip Code			10g. Citizen of What Co	ountry?
	h with	a D	4208 East Capital	Street, NE		20019			United Sta	tes
	ems :	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Specify Yes or No to Rican, etc.)	- 14. Race - Ame Black, Whit	
36	or it		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 🌠 No	Specify:		Specific Afr	ican
Ö	2 should be filed within 72 hours after death with the Maryland and Menth Hygiens. Is marked other than "natural; or Items 23a or 28a-f show sammatic event, the Medical Examinar must be neithfied.	Completed by	3√ Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	16a. Deced	dent's Usual Occupa	tion		16b. Kind of Business	rican
5	nin 72 n "na	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done d DO NOT use retired)	uring most of wo	orking		,
212	d with giene gritha	EO	12 years		ublic.	ation Com	positio	n Specia	list Gover	nment
ng	De file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)						Maiden Surname)	
yla	Ment Ment Marke Marke	၉	Harvey Weakley					e Young		
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic ong.e.		19a. Informant's Name/Relationship (7) Margaret M. Baile						er, City or Town, State, . VA 23320	Zip Code)
<u>စ</u> ်	Health Health tem 27 other to		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of		Date	20c. Location - City or	Town, State
Baltimore,	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 Donation 5 ☐ Other (Specify	Hemovai from State	-	natory or other place		10, 200	8 Washingto	n. DC
a a	permit. Pag Department Important: I eny injury o		21. Sind the of Funerar Service Liter						uneral Home	
ñ	Depa Impo eny ic		Mr.	JO188701	4	001 Benni	ng Road	, NE Was	hington, DC	20019
ė			23a. Part 1. Enter the disease, or composhock, of heart failure. List only	plications that caused the death.	Do not ent	er the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	Respirator	y Fai	1ure				Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as a conseque	ince of):					
3. 2.		_	Sequentially list conditions,	b	nce of):					
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Box	ath ce ittendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	leath 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
0	he de the a	Physician/Med	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4∐Pregnant at time of dea 9∐Unknown	ıth 5∟	Other (specify)				•
Q.	that the de ned by the a detached t		Part II. Other significant conditions or				ın in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
rds	quires n sign	d by	Cerebral Vascula	r Accident, Enc	ephal	opathy		10	Yes 2 □ No 3 □ P	robably 4XUnknown
000	aw requ s been 2 shoul	Completed	Hypertension, Dia	abetes Mellitus				24a. Was	an 24b. Were a	utopsy findings available completion of cause of
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Ita	tician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	-in-				eath [Check only	one)	
5	Physician: this certific al director.	ုင	1 ☐ Yes 2X No	Α-					dence 6 ☐Other (Spe	ecify)
u C	ding P h. After i funera	lo Lo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	8b. Time of Injury	Work	at ? ∕es 2 □ No	28d. Describe	how injury occurred	
Division of Vital Records,	ten feat tor: the	fical	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, far <i>m</i> , str			28f. Location (Street and Number or F	ural Route Number,
2	al or A s after il Dire	Certification;	4 Homicide	building, etc. (Specify)				City or To	wn, State)	
	To the Hospital or At within 24 hours after of to the Funeral Directompletely filled in by	edical (29a. Certifier TV Certifying Ph	ysician: To the best of my knowl niner: On the basis of examination	ledge, deatl	occurred at the tim	e, date and plac	e, and due to the	cause(s) and manner a	s stated.
	To the H within 24 To the F complete	Medi	one)	and manner stated.				1	29d. Date signed (Mon	
	T wit		29b. Signature and title of certifier	1/ Khan		29c. License				
D	(2)		30. Name and address of person who	completed cause of death (he -	22) /T	D0026	024		January 5	, 2008
	(3)		Lester Miles, M				Washino	ton. DC	20017	
2	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ر میا <u>ن .</u> - شم - ا	- III # 300	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , , , , ,		
350	Registr		JAN 0 9 2008	32. Registrar's Signatu	TO ASE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:00 Louis Vincent Keller 1/06/2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's 9412 Eldred Place Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 2/22/1925 82 Director Panama 579-38-6214 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 28a-f show aţ 1 ☐ Yes 2 X No notified Director Prince George's Lanham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ıral", or items 23a or Examiner must be ı U.S.A. 20706 9412 Eldred Place filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1943-46 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Department of Defense 12 Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abbey Casey <u>Louis A.</u> Keller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9412 Eldred Place, Lanham, MD20706 Sook Cha Keller, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of HIMportant: If ite any Injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/14/2008 Cheltenham, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Ave. Hyattsville, MD 20781 Sanning Gasch's Funeral Home, P.A.) asc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MYELODYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy be detached for in the past 12 months? Month Dav Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown perlension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 Yes 2 No 1 ☐ Yes Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760.

death. ie Hospital or Attendi 24 hours after death. ie Funeral Director: A

completely filled in by the Medical To the within 2.

State

MD

100050951

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 8/05

RIVERDALE MD 90737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

510 KENILWORTH AVE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

2008



Registrar

an	1 - State Registrar amend #5 1 1. Decedent's Name (First, Middle, L.						2. Date of Dea Month	nth Day	Year 3	3. Time of Death
an al	Marilyn, L, Ky						Jan	05 2	2008	7:548
er	4a. Facility Name (If not institution, gr		Λ. Ι.,		own, or Location	n of Death		4c. County	of Death	
	University of Mar. 5,500 pial 5,000 rith Marier 6.	Sex 7. Age	(In yrs. last birth	day) If Under 1	Year If Und	ler 24 Hrs.	8. Date of Birtl (Month, Day) (Year)	9. Birthplace Country)	e (State or Fo
	212 30 0655 Usual Residence of Decedent	1 □ M 2 🕅 F	78 ^{Yr}	S. WOTHERS	Jays Hours		DEC 15,		MARYL	
	10a, State 10b. County		10c. City, Town o	r Location					10d.	Inside City Li
ctor	MARYLAND HARE	ORD	HAV	RE DE G	RACE					1 XYes 2 □
Director	10e. Street and Number			10f. Zip C				10g. Citizen of V	What Country	?
	818 ERIE STREI	12. Was Decedent E	vor in II S		1078	Orlain? (Sno	point Voc or No.	USA 14 Bac	e - American	Indian
Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	ver in o.s.	13. Was Deceder If Yes, specify	y Cuban, Mexi	can, Puerto	Rican, etc.)	Blac	ck, White, etc.	
ρ	3 ☐ Widowed 4 🎇 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 5	₹ No Speci	ify:		Specify	BLACI	K
Completed	15. Decedent's l (Specify only highest g		1 (0	ecedent's Usual Give kind of work	done during m	ost of worki	ng j	16b. Kind of Bu	usiness/Indus	try
Idm	Elementary/Secondary (0-12)	College (1-4or 5+) '	ife. DO NOT use NURSES		ידיור א		777 1	OSPITA	т.
	17. Father's Name (First, Middle, Las	st)		NURSES			(First, Middle,	VA D Maiden Surnan		<u></u>
To Be	ELLIS NORMAN				GR	ACE CH	OATES			
-	19a. Informant's Name/Relationship	(Type. Print)	19b. N	Mailing Address (S	Street and Nur	mber or Rura	l Route Numbe	er, City or Town,	State, Zip Co	ode)
	MYRTLE RUFF-CHRIS	STMAS / SIST		CORNS DR		1		AND 210	15	
	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of D	isposition (Name crematory or oth	of er place)		Pate	20c. Location -	City or Town	, State
	4 ☐ Donation 5 ☐ Other (Spec	city)	BERKLE	Y CEMETI		01/1	1/08	DARL	INGTON	, MARYI
	21. Signature of Funeral Service Lic	ensee		22. Name and LISA	SCOTT	FUNER	AL HOME	P.A.		
	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused t	the death. Do no	552 t enter the mode	TEWIS S	as cardiac	r respiratory ar	EDE GRA	A	oproximate
	shock, or heart failure. List on Immediate Cause (Final	4 4 .		,	, .				O O	terval Between nset and Dea
	disease or condition resulting in death)		consequence of							
			acidosis							
ner	Sequentially list conditions, it ary, reducing to initial date cause. Enter Underlying Cause (Disease or injury that initiated events	U.	consequence of							
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Pneumor								
	resulting in deathy East	•	consequence of	:						
dical		d. <u>COPD</u>								
Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy					23d. Da	te of delivery	
ciar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 ☐ Ectopic pred					onth Da	ay Yea
hysi	9 Unknown	9□Unknown								
by P	Part II. Other significant conditions	contributing to death but	t not resulting in t	he underlying cau	ise given in Pa	art I.		obacco use con		,
ted							1 🗆 1	/es 2 No	3 ☐ Probab	ly 4 ☑Unk
Completed							24a. Was autor	sy	Were autopsy prior to comp	y findings ava letion of caus
Con							1□ Yes		death? 1 ☐ Yes 2[□No
Be	25. Was case referred to medical examiner?	Hospital:			Other:		(Check only o			
- To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury			4 🗆			dence 6 Oth		
tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day	Year) Inj	ury M	c. Injury at Work? 1 ☐ Yes 2					
Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At home, farn	n, street, factory,	office		28f. Location (S City or Tox	Street and Numl	ber or Rural R	loute Number
Sert	4 Thomasia	building, etc.	. (Opeony)				Oily of You	ni, olale)		
		Physician: To the best of aminer: On the basis of								
Medical	one)	and manner stat	ed.	290	License numb	er		29d. Date signe	ed (Month Da	V Voar)
	29b. Signature and title of certifier	Advis 1	AA D		117643 ²					
	Kunuberter T. 30. Name and address of person wh				111075	2/11010		Jan.	, xu	00
	Name and address of person Wh	o compreted cause of de	aın i ilem 23a) (T	ype, rint)				re, mn		

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	iryland / I	Department of Certificate of			giene Reg. No. 🤈	nno	01627
	Physici	an	1. Decedent's Name (First, Middle, I	ŕ				2. Date of De Month	Day	2008	3. Time of Beath
	/Medic	al	L. ERMA LEONAL 4a. Facility Name (If not institution, g			4b. City, Town	or Location of De	JANUARY ath		nty of Death	11:00PM ^M
	Examin	ier	CHARLESTOWN RET		EER		NSVILLE			BALTIMO	
	Funeral Director		5. Social Security Number 6 217–20–1571	Sex 7. Age	e (In yrs. last bi	rthday) If Under 1 Yea Months Day			1918	9. Birthpla Countr MARY	ace (State or Foreign ry) LAND
	pui »		Usual Residence of Decedent 10a. State 10b. County	'	10c. City, Tow	yn or Location				10	d, Inside City Limits
	Maryla f shovied at	ro	,	EMORE		TONSVILLE					1 XYes 2 No
	s within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Director	10e. Street and Number 719 MAIDEN CHO	CE TANE RD	112	10f. Zip Code	228		10g. Citizen	of What Countr	γ?
	death v	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Decedent of		(Specify Yes or No	- 14. F	Race - America Black, White, e	
39	urs after al', or ite xamine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced		lo	1 ☐ Yes 2 🛣N		,,		ecify: WHI	
2-0	72 hou 'natura dical E	eted	15. Decedent's (Specify only highest	Education grade completed)	16a	a. Decedent's Usual Occ (Give kind of work don	e during most of v	vorking	16b. Kind o	f Business/Indu	ıstry
21215-0036	within jiene. r than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	SECRETARY	*		U.S.	GOVERN	MENT
pue	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, La	,				lame (First, Middle,	Maiden Sun	name)	
Maryland	should be and Menta marked umatic ev	은	JAMES R. LEONAL 19a. Informant's Name/Relationship			Rural Route Numb	er, City or To	wn, State, Zip (Code)		
	and 2 sealth and 2 sealth and 27 is		ANNE MIELKE/SIS		7	19 MAIDEN C	HOICE LA	NE BR113	CATON	SVILLE,	MD 21228
Baltimore,	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemete	of Disposition (Name of ery, crematory or other p IG HILL CEME		Date 78/2008		on - City or Tov	
3altir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lie		JIKIN	22. Name and Add	ress of Facility HELFENBE	IN & NEW	NAM FU	NERAL H	
	20 2 8 0		23a. Part1. Enter the disease, or co	omplications that caused	the death. Do	200 S. HA	RRISON_S	T EAST	ON, MD	21601	Approximate
2	Physician	g	shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each lir	10.	mentig	, ,				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence						
	l la	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a consequence	of):					
	recuted and -transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	of):					
68760,	ficate be executed physician and s the burial-transit	edical E		d							
68		Medi	IF FEMALE:								
Box	death certific e attending pl d for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐Live birth 4 ☐ Pregnant at	2 Fetal deat	h 3 Ectopic pregnal 5 Other (specify)			23d.	Date of deliver Month	y Day Year
P.0	that the dened by the a	Phys	9 🗌 Unknown	9□ Unknown			-iv i- Dod I	220 Did t	obassa usa s	contribute to the	e cause of death?
Vital Records,	8 5 9	þ	Part II. Other significant condition	s contributing to death bi	at not resulting	in the underlying cause	given in Part I.		Yes 2□N		_
eco	law as b 2 st	Completed						24a. Was	osv	prior to com	esy findings available apletion of cause of
a B	Thage Pag							1□ Yes	rmed? 2. No	death?	2□ No
Ž.	Physician: this certific	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 □ ER/O	utpatient 3 DOA	ther:	Death <i>(Check only o</i> g Home 5 ☐ Resi		Other (Specify)
n or			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day		Time of 28c. In Injury		28d. Describe			
Division	e at at	icatio	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 280 Place of inju	ury - At home, f	M 1 arm, street, factory, office	□Yes 2□No	28f. Location (Street and N	umber or Rural	Route Number,
<u>≥</u>	tal or Ars after al Dire	Certification:	4 ☐ Homicide determine	building, etc				City or To			
	To the Hospital or Atti within 24 hours after de To the Funeral Directo completely filled in by th	Medical		Physician: To the best of caminer: On the basis of and manner sta	examination a						
	To th within To th	Me	29b. Signature and title of certifier	MD		29c. Lice	ense number		29d. Date si	gned (Month, L	
)					onth /# 00 '	(Type (Print)	1147	1	Janes		2008
	6		30. Name and address of person w	Choice 1	19re	CATURS V.	il M	asland	5155	r	
	Sta	ite	31. Date filed (Month, Day, Year)	2008 32 Registra	ar's Signature	Lasti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otato of the		ertificate of		_	Reg. No.	700	8 01	628
П	Physici	an	1. Decedent's Name (First, Middle, L	ast)				2. Date of De	eath Day	v Year	3. Time of	
3,	/Medic			Leith		T-:		January	5, 20	800	1:00	a ^M
	Examir	er	4a. Facility Name (If not institution, g.				r Location of Death		4c.	County of Dea		
	Funeral		Shady Grove Adv 5. Social Security Number 6.		e (In yrs. last birthda)	Rockvi // If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	rth	0.0%	tgomery thplace (State o	r Foreign
	Director		578-12-1988	1□M 2 X F	87 Yrs.	Months Days	Hours Min.	July 23,	1920) Co	ountry) Virgini	
	land ow It		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location					10d. Inside Ci	ty Limits
	A-f sho	ţo	Maryland Mon	topomery	Gait	hersburg					1 □Yes	2√ No
	or 28%	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	ountry?	
	s 23a	rall	922 Beacon Squa		-	20878				JSA	-dtadian	
215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo	s. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecity Yes or No p Rican, etc.)	0-	14. Race - Ame Black, Whit Specif Whit e	te, etc.	
2	"natu	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dec	edent's Usual Occup le kind of work done DO NOT use retire	ation during most of work	king	16b. Ki	ind of Business	/industry	
2121	within iene. than the Me	дшс	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ice Presi			Bar	nking		
מ	e filed al Hygi other vent, ti	Be C	17. Father's Name (First, Middle, Las	it)		100 11001	18. Mother's Nam	ne (First, Middle				
<u>ylar</u>	Menta Menta arked artic ev	TO B	Robert Lee Leith	1				ne Pigg				
, Maryland	es 1 and 2 should be filed of Health and Mental Hygin I Item 27 Is marked other rother traumatic event, the		19a. Informant's Name/Relationship Nancy Leith Bart		8	iling Address <i>(Street</i> 943 Shipwa	atch Driv					
Baltımore,	Pages 1 Iment of He lant: If Iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Metropolit	position (Name of ematory or other plan an Crematory	Zanuar 20	08	Alex	cation - City or	Virginia	
Ball	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Lice	ensee	F	22. Name and Addre rancis J. 00 Univer	ss of Facility Collins sity Blv	Funeral	l Hon Silve	me Inc. er Spri	ng, MD	20901
			23a. Part1. Enter the disease, or co- shock, or heart failure. List onl	mplications that caused y one cause on each lin	the death. Do not e e.	nter the mode of dyir	ng, such as cardiac	or respiratory a	arrest,		Approximat Interval Bet Onset and I	e ween Death
2	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Severe	A.						Onset and I	Journ
	Examiner			Colitis	a consequence of):							
	p .=	ner	Sequentially list conditions, if any, leading to immediate	D	consequence of):							
	ecute and I-trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):							
68/60,	rificate be executed ng physician and as the burial-transit			Duo 10 (01 uo 1	oonooquenoo oi).							
200	tificate g phy: as the	Medical		0.								
O. Box	death ce e attendir d for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3	☐ Ectopic pregnanc	у			23d. Date of de Month	-	Year
ds, r	w requires that the debeen signed by the should be detached	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.				o the cause of c	
Hecords,	siclan: The law requires that the certificate has been signed by the irector, page 2 should be detache	Completed							psy ormed?	prior to death?		available ause of
		Φ	25. Was case referred to medical examiner?			2503-	26. Place of Dea	1 Yes th (Check only o	_^^	1 □Yes	s 2□No	90
or v	this b	To B	1 ☐ Yes 2 № No	Hospital: 1 Hnpatier			4 LI Nursing H	ome 5 Res	idence (6 □Other (Spe	ecify)	
Vision	ending Phys ath. or: After this or he funeral dir	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		y 28b. Time Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injur	y occurred		
Š	ital or Att rs after de al Direct led in by t	Certification:	3 Suicide 6 Could not 4 Homicide determined		ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (City or To			Rural Route Num	nber,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral	edical	29a. Certifier XX Certifying F (Check only one) 2 Medical Example 1	hysician: To the best on the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) , date and) and manner a d place, and du	s stated. ne to the cause(s	s)
	vithin 2 vithin 2 To the I complet	Σ	29b. Signature and title of certifier	1 11,5		29c. Licens			29d. Dat	te signed (Mon	th, Day, Year)	
5		1	7 Flicia 30. Name and address of person who		J		59738		J	anuary	7, 2008	3
	1		Alicia Thakor Mis			cal Cente	r Drive,	Rockvil	le,	MD 2085	50	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 9 200		r's Signature	di)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:42 A M 2008 January 2. Ethel F. Leen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12/18/1914 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 93 Canada Director 500-58-5686 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Director Maryland Anne Arundel **Annapolis** 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number **USA** 2209 River Crescent Drive 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White þ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) vears Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Jane Boyce Joseph Rose 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Sarah Leen/ Daughter 614 Overhill Drive, Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory 1/6/08 4 □ Donation 5 □ Other (Specify) Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Fanoga ervice Licensee 111111111 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Leart failure Immediate Cause (Final disease or condition resulting in death) Vear **Physician** /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Plospital or Attending Pl 24 hours after death. Funeral Director: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No npletely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

2225 Defense Hwy., Crofton, MD 21114

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

JAN 0 7 2008

Paul Berez, M.D.
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Audrey Jean Lewis 2008 /Medical acility Name (If not institution, give street and number) 4c. County of Death Examiner Dicomico Kegional eninsula If Under 1 Year If Under 2 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 229-32-6215 7/2/1930 Director Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "nature" any injury or other traumatic access. 21801 USA 1514 Riverside Dr., B304 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Completed by white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurses aide nursing home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trudy May Charles Garnett Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 E. Grove St., Delmar, DE 19940 19a. Informant's Name/Relationship (Type. Print) Brenda S. Zonko/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/10/08 Gardens Hebron, MD ature of Funeral Service Licensee ²²Holloway Funeral Home Professional Association :294. 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** dal /Medical Due to (or as a consequence of): Examiner Serese Esquestions, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-trar Due to (or as a consequence of) Box 68760. for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. nis certificate has been signed by the director, page 2 should be detached 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division or Vital Records, 1 ☐ Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral I pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

NITO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jouth Division St. Sots 301 Soluty, 403

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** January 5:00P M 7,2008 4c. County of Death Lisa Ann Livingston /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Doctors Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖸 F 38 2/1/1969 Director 216-90-5484 Washington, D.C Usual Residence of Decedent 10d Inside City Limits 10c, City, Town or Location show r 28a-f show notified at 1 ☑ Yes 2 ☐ No Director Prince George's MD Berwyn Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or Examiner must be U.S.A. 20740 7613 Charlton Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pepsi-Cola/Beverage 12 Sales permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacqueline Dolores Walsh Lionel Claude Livingston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7613 Charlton Ave., Berwyn Heights, MD 20740 Jacqueline Livingston, Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 1/11/2008 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Ave. Claudette Dasch Janning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lesperatore **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner music Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Lymphangio leomijo mo ton's certificate be executed Due to (or as a consequence of): Box 68760 attending physician D82. Physician/Medical the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy lor in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 2X No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65909 remi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACEM 4 8118600d Lucierd. , Laiham, MD. 20106 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 0 9 2008 Registrar

Division or Vital Records, P.O. Box 68760, Hospital or AttendIng Physician: within 24 hours at To the Funeral D

Baltimore, Maryland 21215-0036

Certification: 1 👿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0024064

State Registrar

31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S HANTHA MURTHY IM D. 6196

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Registrar

Been & Sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 8 45 AM Carlos 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis, Md 8. Date of Birth (Month, Day, Year) 4 / 09 / 32 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Davs Hours 1 □M 2 □ F 437-40-1684 75 St.Joseph, LA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Anne Arundel Easton 10f. Zip Gode 10g. Citizen of What Country? 10e. Street and Number 21601 USA 8411 Aveley Farm Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 1962 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 □X es 2 □ No Specify Specify: White Completed by 3 Widowed 4 Divorced 1997 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army <u>Army Colonial</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Xavior Thomas Matthews Thelma Cox 19b Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 841 Aveley Farm Road 19a. Informant's Name/Relationship (Type. Print) Donna M. Matthews/Wife Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/08/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Howard Univ. MedSch. Washington, DC 22. Name and Address of FacilityAustin Royster Funeral Home 21. Signature of Euperal Service Licensee 3821 - 14th St., N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) almonory > lyear Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 2☑No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 2 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as slated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

physician and s the burial-trans Division or Vital Records. P.O. Box 68760. as ned by the attending detached for use as page 2 s or Attending Physician: funeral director, this s after death To the Hospital within 24 hours a

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Physician

/Medical

Examiner

Director

Funeral

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Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any injury or other traumatic even.

Physician /Medical

Examiner

State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Medical

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Ame Annopolis Med

1-4-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner		resulting in death)		Due to (o	r as a consequ		/					
	ST. CONT.	_	Sequentially list condition	ns,	b. Down Av. A.	ras a consequ	conc. db.						
_ []	nsit	nine	ri any, reading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	ale	Dae to to	r as a consequ	201100 01).						
2	execu n and al-tra	Examiner	that initiated events resulting in death) Last		c. Due to (o	r as a consequ	uence of):						-
68760	e be (call			_d.								
ξ 89	ig phy as the	Medical			-	•							
Box	Ine law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent preg in the past 12 mont			th 2 ☐ Feta	Ideath 3	Ectopic pregna			2:	3d. Date of deliv	very Day Year
2 0	w requires that the death of been signed by the attend should be detached for us.	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐Unknov	nt at time of d	eath 5L	Other (specify	/	-			
Q	s mar ned by deta		Part II. Other significant	opnditions	contributing to dea	th but not resu	ulting in the u	nderlying cause	given in Part I.	23e. Dio	l tobacco us	se contribute to	the cause of death?
Roberts or Vital Records	quire;	Completed by	- tmx	hys	2mc)				_ 115	Yes 2	No 3□ Pro	obably 4 ☐Unknown
ROBENTS	has bee	plet	0	0						24a. Wa	is an	24b. Were aut	topsy findings available ompletion of cause of
الم الم	ate ha	EO								pei 1 Yes	formed?	death? 1 ☐ Yes	2√ No
/ita	certificate rector, pag	Be (25. Was case referred to examiner?	medical						eath (Check only	one)		
OT 2	rnysi this o al dire	2	1 ☐ Yes 2 No		7		ER/Outpatier	" 3 DOA		Home 5□Re			ify)
ou c	ding rnysician: The lar h. After this certificate has funcral director, page 2	ion:		Pending investigation		, Day Year)	28b. Time o Injury		njury at Work? I∐Yes 2∐No	28d. Describe	e how injury	occurred	
Division	or Attending Proysician; ther death. Virector, Affer this certifice n by the fun ral director, p	Certification:	0 0 0 0 0 0 0 0	Could not be determined		of injury - At ho	me, farm, sti	eet, factory, offi		28f. Location	(Street and	Number or Rui	ral Route Number,
	after after Dire d n b	ertii	4 ☐ Homicide	determined	buildin	g, etc. (Specifi	v)			City or T	òwn, State)		,
Spinson	lo the hospital of Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical C	(Check only 2	Certifying Ph Medical Exar	niner: On the bas	sis of examina	wledge, deat tion and/or in	h occurred at th	e time, date and pla ny opinion, death o	ace, and due to the courred at the time	e cause(s)	and manner as place, and due	stated. to the cause(s)
9	the f	Med	one)	_	and manne	er stated.			ense number			signed (Month	
	S 1 8 -	_	29b. Signature and title of	of certifier	n	715		1.5	8006		DI) h	120r	7 &
	de	Ro	30. Name and address o	f nerson who	completed cause	of death (Item	23a) (Type	1- 1-	3		110	2	0
	1,10		KOFI T	3017	Tty,	70	1 #	0800	tal Dr	1 6	127	Burn	(Cu 1+11)
	Sta		31. Date filed (Month, Da	N 0 7	2008 ^{32. B}	gistrar's Signa	ture	hart .		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 08 0205 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner legional medical Center WICOMICO Date of Birth (Month, Day, Year) State or Foreign **Funeral** 1 M 2□F Months Days Ma Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at 1 Yes 2 □ No Salisbury Wicomico Md **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or ar traumatic event, the Medical Examiner must be 218 USA 1609 West 12. Was Decedent Ever in U.S. Armed Forces? 1 Decedual No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 'oultry Elementary/Secondary (0-12) College (1-4or 5+) Production aboxor Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY HAYMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1609 WEST RO
SALISBURY MOL 21801 19a. Informant's Name/Relationship (Type. Print) Morton (triend Delores Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Delmar, DE 1-13-08 Bennie Smith Funeral Home 917 W. Isabella St 21. Signature of Funeral Service License Salisbury, md 21801 Approximate Interval Between Onset and Death e, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Let only one cause on each line. 23a. Part1. Enter the disease, shock, or hear failure. L Immediate Cause (Final disease or condition resulting in death) **Physician** Lnoxic encephalopath /Medical Due to (or as a consequence of): Examiner po glycemia consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans abetes Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No metastat page 2 anemie 1□ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Salisbury MO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G876 2/14/08 Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** Alfred Myers Kress Õ /Medical Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner oastal 409 alisbur WICOMICO 5. Social Security Number If Under 1 Year | If Under 24 H 8. Date of Birth (Month, Day, Year) 5/15/1918 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 117 M 2□ F 89 Pennsylvania Director 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show orant; If item 27 is marked other than "natural"; or items 23a or 28a-f show they or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Maryland Wicomico Salisbury Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 204 Clover St. by Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 XYes 2 No If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sales lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fi tealth and Mental H Myra Kress Lawrence A. Myers ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Imporant: If item 27 is
any irjury or other trans Nancy Tolan/sister 31659 Hidaway Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 1/8/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE RANAL **Physician** DRSEAJE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FAILURIZ ONGASTIVA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) I□Yes 2□No be detached the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 70 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2005 2410

3x CN

State Registrar

DHMH 17 Rev 1/2001

HOSPICA

0 BOX 1733 SALISBUMY NO 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COASTAL

WARIS

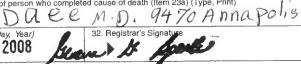
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 12:20PM lanuary , 2008 JAMES R. MEDLEY, JR. 7 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES LANHAM DOCTOR'S HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 10/07/1950) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** MARYLAND 57 214-58-1857 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State r 28a-f show notified at Yes 2 No Funeral Director FORESTVILLE PRINCE GEORGES MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number pe a USA 20747 2737 LORRING DRIVE APT.#103 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 10, Specify: BLACK 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH LABORER marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY AGNES WILLIAMS JAMES R, MEDLEY, SR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 7262 DONNELL PL. APT. #C6 FORESTVILLE, MD 20747 ROBERTA MEDLEY/SISTER Department of Heall Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 01/15/2008 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metast Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): ancer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9☐Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 2 **Y** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 | Homicide i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

31. Date filed (Month, Day, Year) 2008 **PO NAL**

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

20032

29d. Date signed (Month, Day, Year)

Rd. #418 Lanham

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician NellieMayo /Medical 2008 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare Pineview Clinton Prince George's 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Min. 1 □ M 2 □ F Hours Director 578-32-0102 April 11, 1915 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1▼Yes 2 No Director Maryland Prince George's Hillcrest Heights the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene. 2102 Roxanne Place Funeral 20748 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item edical Examiner r Black, White, etc. Black 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify. þ 3 Nidowed 4 Divorced Specify: American Indian er than "natur the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years Clerk Government 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Louis Scroggins Pages 1 and 2 should Sadie Beale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara M. Smith - Daughter Department of Health Important: If item 27 any injury or other troonce. 2102 Roxanne Place Hillcrest Heights, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Jan 12, 2008 Harmony Mem. Park Landover, MD ature of Funer I Servi 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part . Enter the diseas shock of heart failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : certificate 1∏ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**)** No Hospital: Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation spital or Attendi nours after death. neral Director: / death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (tem 23a) (Type, Print) UNE CEATEN WACOOL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 9 2008

Division or Vital Records, P.O. Box 68760,	ne Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.
or Vital	hysician: T
Division 6	ne Hospital or Attending P

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	1	State of Maryland / Department of Health and Maryland / Department of Health and Maryland / Certificate of Death										Reg. No. 2 1 1 8 1 1 6 4 2					
		Decedent's Name (First, Middle, Last)											2. Date of Death 3. Time of Death Month Day Year				
Physicia /Medic		BETTY ANN NO						NOGIC					JAN. 4, 2008 11:22				
Examin	er	4a. Facility Name (I			, , , ,			.,	or Location of Death			4c. County of Death MONTGOMERY					
Funeral		8408 NORTH BROOK LANE 5. Social Security Number 6. Sex 7. Age (In yrs. last by												8. Date of Birth 9. Bir			
Director		205-03-9	1 □ M 2	1□M 2XF 88			Yrs. Months Days Hours Mi			Hours Min.	SEPT.						
and		Usual Residence of Decedent 10a, State 10b, County				10c. City, Town or Location							10d. Inside	e City Limits			
Maryl -f sho fled a	tor	MD. BALTIMORE				KINGSVILLE								ΥΩΥ	es 2□No		
th the or 28a e noti	Director	10e. Street and Number					10f. Zip Code 10g. Citize						itizen of What C	ountry?			
after death with the Maryland or items 23a or 28a-f show miner must be notified at		11932 BELAIR RD.			Everin II C 12 M			21087			anife Van ar h	U.S.A					
ter de Items Iner m	Funeral	1 Never Married 2 Married 1 Yes			med Forces? ∃Yes 2 ∏]		.5.			panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	0-	Black, White, etc.				
ours at	þ	3 ☑ Widowed 4 ☐ Divorced If ☑ Fes, Give Year or Dates:						1 ☐ Yes 21 No Specify:						Specify: WHITE			
72 hc "natur dical	Completed	(Spec	15. Decedent's Education (Specify only highest grade completed)				1 (0	Give kir	cedent's Usual Occupation we kind of work done during most of work			king	16b. i	6b. Kind of Business/Industry			
within ene. than '	gmc	Elementary/Secondary (0-12) College (1-4or 1 2				5+)	"	`life. DO NOT use retired) HOMEMAKER					HOME				
il Hygi other rent, t	To Be Co		17. Father's Name (First, Middle, Last)				1					e (First, Middl	st, Middle, Maiden Surname)				
Menta Menta arked atic ev		TI	HOMAS	ROSS	FJ	GART					MYRZA GRACE SM						
2 sho		19a. Informant's N									nd Number or Ru						
1 and Health em 27		ADRIENNI 20a. Method of Dis		ANG/DAL	GHTER	20b. P	Place of D	Dispositi	ion (Name of	f		BETHE:	_	MD - ZU C Location - City o			
Pages ent of nt: If It y or o		1 ☐ Burial 2	Cremation	3 Remov	al from State	C	-		tory or other p		1	-2008	RT	VERDALE	. MD.		
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; any injury or other traumatic event, the Medical Exarone.		4 Donation 5 Other (Specify) CHAMBERS CREMATORY 1-8-2008 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.															
g a m g		M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate															
		23a. Part1. Enter 1 shock, or hea Immediate Cause	art failure. Lis	t only one cau	s that caused se on each li	ne.	n. Do noi	t enter	the mode of d	dying	such as cardiac				Interval	Between nd Death	
Physician /Medical		mindedate Cause (Final disease or condition resulting in death) a. Due to (gras a consequence of):											Dn	75			
Examiner		Sequentially list co	anditions	b	V												
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury															
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icate be executed physician and s the burial-transit	edical																
ertifica ding ph	Med	IF FEMALE:															
death certifica attending ph for use as t	Physician/M	23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)										23d. Date of de Month	Day	Year			
t the d by the	hysi	1 Yes 2 No 9 Unknown 9 Unknown															
w requires that the de been signed by the s should be detached	by	1 Tark Substitution Continuous Co											obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
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The la	Completed								1□,				autopsy prior to completion of cause of death?				
iding Physician: h. : After this certifica funeral director, p	To Be	25. Was case referred to medical examiner? DA Other: DA											DAUGH	TER'S			
y Physer this eral di		Tes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA									4 Nursing Home 5 Hesidence 6 Mother (Specify) HOM					HOME	
ath. or: Afte	atio	1 Natural 5 Pending (Month, Day Year) 2 Accident (Month, Day Year)						28b. Time of lnjury M 28c. Injury at Work? 28d. I ☐ Yes 2 ☐ No									
i or Atte after de Directe i in by ti	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)														√umber,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier Check only One) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and methors tated.															
ro the within : To the	Mec											ate signed (Mor	(Month, Day, Year)				
7		1 de	2)(Sie	e Lumome				83400d				10	5 di	7 2008		
>		30. Name and add	ress of person	who complet	ed cause of	leath (Item	n 23a) (Ty	ype, Pri	int) 2 rp	-	one &	cal 1	0.1	CPr			
Sta	to	31. Date filed (Mor	UBK	FC HO	32 Registi	rar's Signa	ature		2110	6	Sperm	las 1-	<u>()</u>	2090.			
Registr			AN OS		Bergu	w d	KA	100	6		V _						

14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry High School 18.Mother's Name (First, Middle, Maiden Surname) Elliott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10882 24012 Pecan Grove Lane, Gaithersburg, Maryland 20c. Location - City or Town, State Pottstown, Penna. Name and Address of Facility
Moles worth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Nursing Home 5 Residence 6 Other: 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m. S O.C.M.E. January 9, 2008 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Figistrar's Signatur State 2008 JAN Registrar DHMH 17 Rev 1/2001 **ORIGINAL** OCME

0552 hrs

Country) Maryland

10d. Inside City Limits

Yes 2 X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 15 State of Maryland / Department of Health and Mental Hygieney are the per fh, g876,02/16/08dhb of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6, 2008 8:46 January Hyman Newman /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 93 20, 1914 New York Director 140-03-6024 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No Director Middletown New York Orange 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n 10940 USA 41 Prospect Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or Items traumatic event, the Medical Examiner mo 11. Marital Status Black. White, etc. 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【XNo 3altimore, Maryland 21215-0036 Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. U.S. Government Social Security Adjuster 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yetta Fried Isaac Newman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prospect Street Middletown, NY 10940 41 Carole Hayes/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 ortant: If i 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/10/2008 North Lauderdale, FL Star of David 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Athero Schoolic Heart Distance 1-Pan /Medical Due to (or as a consequence of) **Examiner** enentio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed herter physiclan and s the burlal-trans Due to (or as a consequence of): Box 68760. Physician/Medical bu IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury a₩ Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide e Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number 0

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 0 8 2008

Rakesh Arora 14300 Gallant Fox Lane Bowie, MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Alma Eudora O'Toole Januar 8 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington County 9. Birthplace (State or Foreign Country) Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday, If Unde 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2XF Months Days Min. 232-54-8234 Director Dec 7,1916 West Virginia Usual Residence of Decedent t be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 13515 Cherry Tree Circle U.S.A. 14. Race - American Indian, Medical Examiner must 21742 Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 0. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 ☐ Divorced Specify: White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker 12 Personal Residence permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important; If item 27 is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William C. Tomlinson Carrie A. Morgan Tomlinson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William O'Toole.III-son 53150 Holly Fem Ct. South Bend, IN 46637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 01-12-2008 | Hagerstown, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 21. Signature of Funeral Service Licensee Saff Kaitlin 23a. Part1. Enter the disease, o' complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dilatton /Medical (or as a consequence of) Examiner CVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 2 1 ☐ Yes 2 ₹No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy 1∐ Yes 2. No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 2 ER/Outpatient 1 Inpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

State Registrar

Medical

completely

To the I To the

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29a. Certifier

(Check only one)

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Division

and manner stated.

2008

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

11110 Medical Campus Rd.

29d. Date signed (Month, Day, Year)

Hage Istown, MARLY

3H-1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Shah

JAN 1 0 2008

650 Thomas
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mas Johnson Drive, Frederick MD 21702 gnature

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1.6.2008

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For State	State of Maryland / Department of Health and Mental Hygiene 1
State	0 - 456 - 4 - 4 5 - 4

سنيي					lental Hygi	en@ 008 g. No.	01647
	Physici /Medi		1. Decedent's Name (First, Middle, Last) John Moring Porter		2. Date of Death Month January	Day 2008 Year	3. Time of Death 10:00 AM
	Examir		4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Annapolis If Under 1 Year If Under 24 Hrs.	8. Date of Birth	i	Arundel
	Funeral Director		261-58-2455 XX M 2□F 65 Yrs. Usuat Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, July 14,	1942 Or	nplace (State or Foreign untry) egon
11215-0036	to Health and Mental Hygiene. If frem 27 is marked other then "natural", or Itema 23a or 28e-f show or other treumatic event, the Medical Examiner must be notified at	i Director	10a. State 10b. County 10c. City, Town or town or town and Name Arundel 10c. Street and Number 10c. Street and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town and Number 10c. City, Town or town or town or town and Number 10c. City, Town or town or town or town and Number 10c. City, Town or town	Annapolis 10f. Zip Code 21401	10	g. Citizen of What Co United St	
036	al', or Itema 2	by Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 Thin Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	rican Indian,
Maryland 21215-0036	giene. er then "natur i the Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Chemist	ing	Forensi	
aryland	nd Mental Hygie marked other matic event, the	To Be C	17. Father's Name (First, Middle, Last) William M. Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	18. Mother's Name Anne J. ing Address (Street and Number or Run.			in Code)
imore,	Dominication of Health and Indianate		William M. Porter / Father 20a. Method of Disposition 1 □ Burial M. Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2 River Crescent D	rive And Date 20 2008 H n M. Tayl	napolis,Ma Oc. Location - City or Baltimore, Lor Funera	ryland 2140 Fown, State Maryland 1 Home,Inc.
	hysician /Medical		23a. Pan1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.		or respiratory arres	st,	Approximate Interval Between Onset and Death
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Hecords, P.	been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 🗆 Yes	7 -	obably 4 Unknown
		Be Completed	25. Was case referred to medical	26. Place of Deat	24a. Was an autopsy performed 1 Yes 2	ed? prior to death? No 1 □ Yes	topsy findings available ompletion of cause of
DIVISION OF VITA	h. After th funeral	Certification: To E	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 3 Suicide 4 Homicide Hospital: 1 Inpatient 2 ER/Outpatient 2 Sea. Date of Injury (Month, Day Year) 28e. Place of tnjury - At home, farm, s building, etc. (Specify)	of 28c. Injury at Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)	28d. Describe how	eet and Number or Ru	
To the Hospita	within 24 hours after deat To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea control on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	red at the time, dat	e and place, and due d. Date signed (Month	to the cause(s)
\	ox do	Ÿ	30. Name and address of person who completed cause of den (Item 23a) (Type 22.2.5.5.	D 00297	11 0 C	01/02/2	008 Berez mp
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 8 2008 32. Registrar's Signature	head .	1 10	101 01	- (11 - 77
DHM	1 17 Rev 1/20	001	7	GINAL			

			For State Registrar	State of M	laryland		artment of F <i>rtificate of</i>	lealth and I <i>Death</i>		giene Reg. No. 2 [108	0161	ρ
	Physici	an	Decedent's Name (First, Michael Company)						2. Date of Dea	ath Day	Year	3. Time of Death	
(/Medio	al -	4a. Facility Name (If not institut	ion, give street and number	·)		4b. City, Town, o	r Location of Death	JANUAR	4c. Count	Year 2008	7:40 P	M
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	Funeral Director		5. Social Security Number 404-24-1709 Usual Residence of Decedent	6. Sex 7. A 1 X M 2 ☐ F	ge (In yrs. Ia	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	y, Year)	9. Birthpla Count KY •	ace (State or Fore ry)	gn
	yland now at		10a. State 10b. Coun	*	10c. City,	, Town or Lo	cation				10	d. Inside City Lim	ts
	ne Mar Ba-f st stified	Director		Arundel	Se	vern						1 ☐ Yes 2 ☐ X	10
	with the		10e. Street and Number 7977 Telegra	anh Poad			10f. Zip Code 2114			10g. Citizen of		ry?	
	death	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S	3. 13. V		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	USA 14. Rad	ce - America ck, White, e		
5-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorce	arried 1 Maryes 2 □	NAMMII		1 ☐ Yes 2 🔀 No	Specify:	o raidan, etc.)	Specil		White	
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Baitimore,	of F		4☐Donation 5☐Other		Fai	metery, cren rview	sition (Name of natory or other plac Cemetery	į		20c. Location owling	Green	KY	
ga	permit. Pag Department Important: I any Injury o once.		21. Signature of Fyneral Service	a A AM	1	He	Name and Addre	ss of Facility uneral H	ome P.A.	12 Rid	lgely .	Ave 21401	MD
			23a. Part1. Enter the disease, shock, or heart failure. Li	r complications that cause st only one cause on each	d the death. line.				or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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.C. 60X	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 4 ☐ Pregnant a	2 Fetal	death 3 □	Ectopic pregnancy Other <i>(specify)</i>	y			ite of deliver	y Day Year	
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vital Records,	@ S €	Completed								rmed?	prior to com death?	sy findings availat pletion of cause of 2 14 No	ile f
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0	g Phy er this eral di	n: To	27. Manner of Death	28a. Date of Inj		28b. Time of	, all box	4 □ Nursing H	ome 5 🗆 Resid 28d. Describe h)	_
VISION	endin sath. or: Aft	atio	Z Accident	tigation	ay rear)	Injury		Yes 2 □ No					
2	tal or Att s after de al Direct ed in by i	Certification:		refined 200. Flace of in	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numl n, State)	ber or Rural	Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 ertify (Check only one) 2 Medica	ring Physician: To the best al Examiner: On the basis and manner s	of examination	ledge, death on and/or inv	occurred at the tile restigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)	
	To t To t	Σ	29b. Signature and title of certif	ier	= Mr)	29c. Licens		1	29d. Date signe			
	(CX)	Pu	30. Name and address of person	n who completed acres -4		Day (Time I	Deint)	\$ 63430					
	100		RAVITE T I(H) 31. Date filed (Month, Day, Yea	UNKHY	540	1 OL	1) COURT	RO RA	NOAUST	OWN	MO	2/133	
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page 2 should director

The law requires that the death certificate be executed 24 hours a

To the Hospital or Attending Physician:

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Medical

the within To the

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Cother (Specify) HCSPice Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O. M.D.: 5302 CHINABERRY DR., SALISBURY, MD GREGORIO M. BELLOSO

2008

State Registrar

31. Date filed (Month, Day, Year) JAN 0 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Juanita Eleanor Parrett 2008 6:00 a M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice, Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🖾 F 216-38-2982 66 Director June 13, 1941 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Cecil Port Deposit Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Locust Lane 21904 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Eight Years College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Keen Virginia Little ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Lawrence (daughter) Locust Lane, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State R.A. Ferris & Co., Inc. 01/09/08 West Chester, Pennsylvania 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licen Perryville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) peritonea **Physician** Due to (or as con equence of): scrous carcinoma /Medical Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy performed Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence Pice Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year

JAN

.O. Box 68760,

Division or Vital Records, P.

29c. License number

N. Eutaw St. Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** SYLVESTER VINCENT ROBERTS 6:25 PM 2008 Jan /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Genesis HealthCare -The Pines Easton Talbot Year If Under 24 Hrs. Days Hours Min. DEC 31, 1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1XM 2□F Months 80 COLORADO 522-30-2671 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ¹₹Yes 2□No Director TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 610 DUTCHMAN'S LANE USA 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 No Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC EDUCATION TEACHER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be LEONARD ROBERTS SYLVIA NELSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 1922 CHAPARRALL COURT, CROWNSVILLE, MD 21032 C. RENEE MICHAEL/DAUGHTER Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition Department of h
Important: If Ite
any Injury or of
once. 1 ☐ Burial 2 **T** Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (*Specify*) CHESAPEAKE CREMATION CTR 1/8/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 OSTIZUWSKi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Body Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy has 2**X** No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 250 No 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier lowlen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+VA UTCHMAN'S LANG ROWLEY MICHAEL 31. Date filed (Month, Day, Year) State JAN 0 9

DHMH 17 Rev 1/2001

Registrar

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		1. Decedent's Name (First, Middi	le, Last)					2. Date of Deatl Month	h Day	Yeer	3. Time of Death
rysicia Medic		Teresa Rascona						January 7,	2008		11:20 a
kamine		4a. Facility Name (If not institutio	n, give street an	nd number)		4b. City, Town, or	Location of Deatl	1	4c. Count	y of Death	
		4705 Powder House	Drive			Rockville			Montgo		
neral		5. Social Security Number	6. Sex	_	yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)	9. Birthp	place (State or Fore ntry)
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	-	Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or	Location					10d. Inside City Lin
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) Ber	Funerai	11. Marital Status	Am	Decedent Ever	In U.S.	If Yes, specify Cuba	in, Mexican, Puer	o Rican, etc.)		ack, White,	
를	by F	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Ye	Yes 2. ∏ No es, Give rorDates:		1 ☐ Yes 2 ☑ No	Specify:		Spec	ify: Whit	to
a E	De l		nt's Education	10104103.	16a Dec	cedent's Usual Occup	ation		16b. Kind of		
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t'		17, Father's Name (First, Middle	, Last)		DC4	Inis ci ess	18. Mother's Na	ne (First, Middle, I	Maiden Suma	ıme)	
	Be c	Pasquale Cicala					Concett	a DiBella			
Tati	ဥ	19a. Informant's Name/Relation	ship (Type, Prin	nt)	19b. Ma	iling Address (Street			. City or Tow	n, State, Zij	p Code)
trau		Gina Sciuto - Daug		•		Powder House					
important, it will straumatic event, the Midical Examiner must be rutified at once.		20a. Method of Disposition	311001		20b. Place of Dis	position (Name of		The second secon	20c. Location		own, State
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jury		`4 □Donation 5 □Other (Gate of He	22. Name and Addre	1/9/	-			Maryland
eny ir		21. Signature of Funeral Service	a Cicouzao	0 0	0		דמ	mple Tribut			Cremation (
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Division or Vital Records, P.O. Box 68760,	o	Vita	E	eco	rds,	٦.	o	B 0	89	921	Ć,
ital or Attending Physician: The law requires that the death certificate be exect	Phy	siclan:	The	law re	quires	that t	he d	eath ce	ertifica	ite be	exec
rs after death.											
ral Director: After this certificate has been signed by the attending physician and	r this	certific	ate h	as bee	en signe	ed by	the	attend	ng ph	ysicia	in an
led in by the funeral director, page 2 should be detached for use as the burial-tra	raldi	rector	page	2 sho	uld be	detac	hed	for us	38 #	IId at	rial-tra

Physicia /Medic		Gloria Jean Reed				January	Day 8	2008	7:47 P M
Examin		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or L				ounty of Death Freder	
Funeral Director	Ŷ	5. Social Security Number 219-44-7727 6. Sex 1 □ M 2 ☒ F	birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Ye <i>ar)</i>	9. Birth	place (State or Foreign intry)
pug 💉	8	Usual Residence of Decedent 10a, State 10b, County 10c, City, T	own or Loc	cation					10d. Inside City Limits
Manylk f sho ied at	ō	Maryland Howard Mt. A.							1 □Yes 2 XNo
r 28a	Director	10e. Street and Number	II y	10f. Zip Code		T	10g. Citizer	n of What Cou	intry?
th wit 23a o ust be		1434 Long Corner Road		21771			USA		
er dea Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No Rican, etc.)	. 14.	. Race - Amer Black, White	
hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by F	1 ☐ Yes 2 No If Yes, Give 3 No Widowed 4 ☐ Divorced Year or Dates:	1	□Yes 2XINo	Specify:		S	pecify: Whi	te
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Inpportant of Heatth and Mental Hygiene. Inpportant: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		15. Decedent's Education 1 (Specify only highest grade completed)	6a. Deced	ent's Usual Occupat	tion	kina		of Business/li	
vithin 7	Completed	Elementary/Secondary (0-12) Coilege (1-4or 5+)		kind of work done du OO NOT use retired)		ung			
filed w Hygie ther ti	Ŝ	12 (Cafet	eria Work	er 18. Mother's Nam	e (First, Middle,			Public Sch.
ld be lental ked o ic eve	To Be	David Howard Duvall			Margaret	Kather	ine D	11V211	
shou and M s mar			19b. Mailin	g Address (Street ar					ip Code)
and 2 ealth a n 27 ls				Florence					21797
ges 1 t of Hi If Iter		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	e of Dispos etery, crem	sition (Name of natory or other place)	Date	20c. Locat	tion - City or T	Town, State
it. Pa rtmen rtant: njury		4 Donation 5 Other (Specify) Pine 2(. Signature of Foneral Service Licensee		Cemetery					laryland
permi Depa Impo any Ir		Signature of Edneral Service Licensee		401 Ridge					uneral Home 20872
EN AT		23a. Part Enter the disease, or complications that caused the death. I					-	Jana	Approximate Interval Between
Physician		shock, or heart failure. List only one cause on each fine. immediate Cause (Final disease of condition a	wia.						Onset and Death
/Medical		resulting in death) Due to (or as a consequent	ce of):						
Examiner	_	Sequentially list conditions, if any leading to immediate b. Hypatem Due 6 for as a consequent		<u> </u>					
rted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		tu na -t	P (171)	м			
execuin and ial-tra	Exar	that initiated events resulting in death) Last C. Due to (or as a consequen	ce oil:	John	CAPIU				
ate be nysicia he bur	ical								
death certificate be executed eath certificate be extending physician and d for use as the burial-transit	sician/Medical	IF FEMALE:	,						
attend for us	cian	23b. Was decedent pregnant in the past 18 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	ath 3	Ectopic pregnancy Other (specify)			230	d. Date of deli- Month	very Day Year
t the d by the ached	Physi	1 □ Yes 2 No 4□ Pregnant at time of death 9 □ Unknown							
The law requires that the the has been signed by to age 2 should be detach	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the un	derlying cause giver	n in Part I.	23e. Did to			the cause of death?
equire sen si						101	res 2	No 3∏ Pro	obably 4 □Unknown
e law has b	Completed					24a. Was		prior to o	topsy findings available ompletion of cause of
n: Th ficate r, pag		OF Management to medical				1□ Yes	2 1 No	death? 1 ☐ Yes	2 No
Attending Physician: r death, ector: After this certific by the funeral director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Napatient 2 □ ER.	/Outpatient	Othor	26. Place of Dea	th <i>(Check only o</i> ome 5 ☐ Resid	,	Tother (Spec	vi64)
g Phy ter this	⊢ ⊦	27. Manner of Death 28a. Date of Injury 28	b. Time of injury	28c. Injury Work?		28d. Describe I			119)
endin sath. or: Af he fur	atio	2 Accident investigation		M 1 □ Y	es 2 □ No				
	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tox		vumber or Ru	ral Route Number,
spital ours a neral I		29a. Certifier 1XCertifying Physician: To the best of my knowle	dge, death	occurred at the time	e, date and place	and due to the	cause(s) ar	nd manner as	stated.
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only one) Medicai Examiner: On the basis of examination and manner stated.	and/or inv	estigation, in my op	inion, death occu	rred at the time,	date and pl	ace, and due	to the cause(s)
To the Comp	M	29b. Signature and title of certifier	٠ ٨	29c. License				signed (Month	
		1 My He Want	W	DO	035	106	Jan	1 5,	2008
7		30. Name and address of person who completed cause of death (item 23		ľ					
Sta	te.	Myung Hee Nam, MD, 400 West Seve 31. Date filed (Month, Day, Year) 32. Begistrar's Signature			ederick	, Maryla	nd_ 2	1701	
Registr		31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	Ap	ede					
	-	· · · · · · · · · · · · · · · · · · ·	-						

			1 - For Amend #5 Per FH G875 1/29/08 JH Cert.	tment of Health and N <i>ificate of Death</i>	lental Hygier/ Reg. r	ne	/ F F
	115		1. Decedent's Name (First, Middle, Last)	·	2. Date of Death	ZUUU SITIM	e of Death
	Physici /Medic		Ethel Marita Randall		January 4,	2008 Year	OAM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
		MS.		lyattsville If Under 1 Year If Under 24 Hrs.		rince George'	
82	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea June 20, 1	9. Birthplace (Sta Country) Washingt	
	land ow		10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside	City Limits
	leath with the Marylan ns 23a or 28a-f show must be notified at	tor	Maryland Prince George's Upper Mar	·1boro		1)(1)	'es 2 □ No
	th the or 28a e not	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?	
	ath wi 23a ust b		19 Queen Anne Bridge Road	20774	USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	1 XNever Married 2 Married 1 Yes 2 No If Yes, Give 1 □	as Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexican, Puerto ☑ Yes 2ሺ No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - American Indian Black, White, etc. Specify:	,
21215-0036	tural		15. Decedent's Education 16a, Decede	nt's Usual Occupation	16b	Black Kind of Business/Industry	
15	nin 72 n "na Medio	Completed	(Specify only highest grade completed) (Give kill life. DC Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of work O NOT use retired)	ing	Tand or Business/madsity	
212	d within giene. er than " the Med	mo.	12 Secret	ary	Fed	leral Governme	nt
ng	e filed and Hygie a other event, the	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	en Surname)	
Maryland	2 should be a nand Mental is marked or raumatic eve	2	John M. Randall	Gladys E			
Mar	12 sh h and 7 is m traum			Address (Street and Number or Rui	· ·	,, -,,	0077/
e,	1 and 2 Health em 27 i		Gladys E. Randall/ Mother 19 Qu 20a. Method of Disposition 20b. Place of Disposit	ieen Anne Bridge		Location - City or Town, State	
Baltimore,	Pages nent of int; if its iry or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metro	ntory or other place)			
Ħ	# ₹ ₽ ₽	1	4 □ Donation 5 □ Other (Specify) Crema 21. Signature of Funeral Service Licensee 22. N	Name and Address of Facility Rob		xandria, VA	m.o.
ñ	permi Depa Impo any ir			000 Annapolis Roa			.ne
	Dhysisian	7 7	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approxii	nate Between nd Death
)	Physician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	tre Cardiovase	WER O	stease year	115
la.	Examiner						
	p #	ner	fany, leading to immediate cause. Enter Underlying				
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.				
68760,	be ex cian a	Ē	Due to (or as a consequence of):				
387	physi the I	dical	d				
P.O. Box (The law requires that the death certific ate has been signed by the attending paage 2 should be detached for use as	Physician/Me		ctopic pregnancy Diher (specify)		23d. Date of delivery Month Day	Year
۳.	that the property of the prope		Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Part I.	23e. Did tobacc	use contribute to the cause	of death?
rds	quires n sigr ald be	Completed by	End & type / Leval Disease		1 ☐ Yes	2 No 3 Probably 4	Unknown
00	aw requir s been s	lete	Do this ten Mille The		24a. Was an	24b. Were autopsy findin	gs available
Ä	The la	mo	- Out W		autopsy performed? 1 Yes 2 ☑		if cause of
ita	lan; rtifica ctor, p	BeC	25. Was case referred to medical	26. Place of Deat	h (Check only one)	10 10 100	
<u> </u>	is of dire	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)	
Division or Vital Records,	ding P. J. After t funera	iio	27. Manner of Death 28a. Date of Injury 28b. Time of Injury Injury 1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury	Work?	28d. Describe how in	ury occurred	
Sio	ttend leath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At home farm street	M 1 Yes 2 No			
<u>></u>	after of Direct In by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	i, ractory, office	City or Town, Sta	and Number or Rural Route N ite)	umber,
	spital lours neral		29a. Certifier 1 ertifying Physician: To the best of my knowledge, death o	ccurred at the time, date and place.	and due to the cause	(s) and manner as stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investore) and manner stated.	stigation, in my opinion, death occur	red at the time, date a	nd place, and due to the caus	e(s)
	To ti Withi To ti comp	Ž	29b. Signature and title of certifier	29c. License number	29d. [Pate signed (Month, Day, Yea)
	0 -1		Janllen levil in	101852	17	NUARY 7.2	008
	L	W	31. Date filed (Month, Day, Year) JAN 0 8 2008 Multiple Cause of death (Item 23a) (Type, Prince 23a) (Type	eenston R1	Hatt	villetus 20	781
	Stat	e	31. Date filed (Month, Day, Year) 1. N. O. 8. 2008 32. 9 gistrar's Signature	7,0	2 4		~ .

-	For State	State of	warylar				nd Mental H	ygiene	2008	01651
	Registrar 1. Decedent's Name (First, Middle,	(ast)		Cei	tificate o	T Death	2. Date of I	Reg. No.		3. Time of Death
an		hington	Roger	's			Month D	Day	- 2-00	
al er	4a. Facility Name (If not institution,			,	4b. City, Town	, or Location of			County of Death	
		ne med			50	Usbur	/		WICON	
-	5. Social Security Number 260-32-6605 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (<i>In yrs.</i> 83	last birthday) Yrs.	If Under 1 Ye Months Day			Day, Year)	Cou	place (State or Fore Intry) Orgia
يَ	10a. State 10b. County Maryland Wico	mico		y, Town or Lo						10d. Inside City Lim
Director	10e. Street and Number				10f. Zip Code	9		10g. Citi.	zen of What Cou	intry?
	602 S. Kaywood	Drive			218	04		U	SA	
Funeral	11. Marital Status	12. Was Dece Armed For	rces?	.S. 13. \	Vas Decedent of f Yes, specify C	f Hispanic Origii uban, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)	lo-	 Race - Ameri Black, White, 	
ò	1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	If Yes, Giv Year or Da	е		I⊡Yes 2⊠XN	,,.				hite
Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	college (1	-4or 5+)	Give life. L		cupation ne during most o ired)	f working		nd of Business/Ir arpentry	
ည်	17. Father's Name (First, Middle, L	_ast)		carpe	11001	18. Mother's	Name (First, Midd			<u> </u>
0	Ambern Dewey Ro			-,			ie Painte			
	19a. Informant's Name/Relationsh Arvil D. Rogers						or Rural Route Num , Salisbu			p Code)
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Stata 6	cemetery, cren .COM1.CO	sition (Name of natory or other p Memoria	וב וב	Date /11/08		cation - City or T lisbury,	
-	21. Signiture of Funeral Service L	icensee		Park FSP	Name and Add HOLLOWA	ress of Facility Y Funera		rofes	sional A	ssociatio
al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
rnysician/inedical	d. IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Output									
2	Part II. Other significant condition	ns contributing to de	ath but not res	ulting in the ur	iderlying cause	given in Part I.			se contribute to t	the cause of death?
nataldition							24a. Wa	s an opsy formed?		opsy findings availal empletion of cause o
	25. Was case referred to medical						1□ Yes	2 No	1 ☐ Yes	2□ No
D D D	examiner? 1 Yes 2 No	Hospital:	npatient 2□	ER/Outpatien	t 3 2 DOA)ther:	f Death <i>(Check only</i> ing Home 5 ☐ Re		S DOther (Special	(f ₁)
- 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month)	<u> </u>	28b. Time of Injury	28c. In		28d. Describe			97
Celunication.	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and Zoe. Place	of injury - At ho ig, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, offic	ce	28f. Location City or To	(Street and own, State)	d Number or Run)	al Route Number,
Medical	29a. Certifier (Check only one) 1 S Certifying 2 Medical E	Physician: To the xaminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the restigation, in m	time, date and y opinion, death	place, and due to th occurred at the time	e cause(s) e, date and	and manner as s place, and due t	stated. to the cause(s)
2	29b. Signature and title of certifier	1 7			29c. Lice	nse number		29d. Date	e signed (Month,	Day, Year)
	30. Name and address of person w	Amy completed asset	of death /lic-	22a\ /T !	O Print)	2091	2	- 1	1/1/01	8
			TATH DISSOUR	LCOB) LLVDA.	rifft)					

State Registrar

		_	State of Maryland / Dep				9	
		1 - For State Registrar		rtificate of			g. No 2 1 1 2	01657
Physici /Medic		1. Decedent's Name (First, Middle, Last) William F.	Richardson			2. Date of Death Month January	Day Year	3. Time of Death 7:39 M
Examir		4a. Facility Name (If not institution, give s			r Location of Death	1	4c. County of Deat	h
- Fundament		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	SILVER If Under 1 Year	SPRING If Under 24 Hrs.	8. Date of Birth	Montgom	ery hplace (State or Foreign
Funeral Director			M 2□F 88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 9/7/1919		ryland
aryland show	_	10a. State 10b. County	10c. City, Town or Le	ocation				10d. Inside City Limits
the Ma 28a-f s	Director	Maryland Montgome 10e. Street and Number	ery Rocky				022	1 X Yes 2 No
of the died within 72 hours after death with the Maryland and Mental Hyglene. In a worked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at		4801 Tallahassee	Ave.	10f. Zip Code	0853	10	g. Citizen of What Co USA	untry?
death	Funeral	11. Marital Status	Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	
s after ", or ite	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	I No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	1 ☐ Yes 2 ☑ No	Specify:	o riloan, etc./	2 "	white
2 hour atural	ed b	15. Decedent's Educ	ation AirCorn 16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Business/	
thin 7; e. an "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king		·
lled wi Hygien her th ht, the	S	12. Father's Name (First, Middle, Last)	- bus	driver	40 Mathada Na	- (Final States S.	public	transit
d be fi ental H ked ot c evel	o Be	Frank L. Richards	son			ne (First, Middle, M eth Bisho		
shoul and Mo	ř	19a. Informant's Name/Relationship (Typ	′ !	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, 2	Zip Code)
1 and 2 Health a em 27 is ther tra		Virginia L. Richar					Oc. Location - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State 20b. Place of Disponeracy, crewitten, Memorial	1/10		Salisbury,		
permit. Departimontal		21. Signature of Funeral Service License		HOTTOWAY 501 Snow	Funeral Hill Rd.	Home Prof , Salisbu	essional ary, MD 218	Association 304
		23a. Part J. Enter the disease, or complice shock, or heart failure. List only on						Approximate Interval Between
Physician	01 /	immediate Cause (Final disease or condition resulting in death)	CARDIAC ARREST					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
t d	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	CARDIOMYOPATHY Due to (or as a consequence of):					
be executed ician and burial-transi	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	DEMENTIA Due to (or as a consequence of):					
icate be executed physician and s the burial-transit	cal	L d.	RESPIRATORY ARRES	T				
leath certific attending ph	ın/Med	23b. was decedent pregnant	ic. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3[Testania programa			23d. Date of del	ivery
The law requires that the death certificate tte has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>			Month	Day Year
res that signed b	by	Part II. Other significant conditions conf	ributing to death but not resulting in the u	inderlying cause giv	en in Part I.		acco use contribute to	
w require been sig	eted							obably 4 \ Unknown
The lav	Completed					24a. Was an autopsy perform	prior to o	topsy findings available completion of cause of 2 No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	oenitel.	0.11		th (Check only one		
this al dir	- To	1 ☐ Yes 2 ☒ No	ospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 28a. Date of Injury 28b. Time of		4 Nursing H	ome 5 Resider	oce 6 Other (Spec	cify)
nding I ath. r: After e funer	ation	1 X Natural 5 ☐ Pending investigation	(Month, Day Year) Injury	Wor	k? Yes 2 □ No	Edd. Describe not	vinjury occurred	
or Atte after des Directo in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, str building, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet a <i>nd Number or Ru</i> State)	ıral Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	cian: To the best of my knowledge, deat er: On the basis of examination and/or in	h occurred at the tin	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
Fo the vithin ? omple	Mec	29b. Signature and title of certifier	and manner stated.	29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
T. JA		mil	en	D560	063		January 5,	
10x B		30. Name and address of person who con	npleted cause of death (Item 23a) (Type,	Print)	ver Spri	na, MD 20	910	
Sta	te	Dr. Kanwaljit Nagi 31. Date filed (Month, Day, Year)	32. Regierar's Signature		TOL OPER			
Registr		JAN 0 8 2	008 Meser It	docule				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7,2008 10:33A Α. Warren Rogers January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** <u>5</u>4 Yrs. Months Days 1 ☑ M 2 ☐ F Aug. 31, 1953 MD. 579-74-4380 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Director Md. PG Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 United States 3513 Riviera Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Auto Mechanic 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Spence Charles Rogers Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3513 Riviera Street Temple Hills, Md. 20748 Thelma Rogers/mother Department of Healt Important: if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Veterans Cem. 1/14/08 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 anice 23a. Part/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 day arrhy Thmia **Physician** Cardiac /Medical Due to (or as a consequence of): Examiner 2 days Acute renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence 3f) Examiner 2 days The law requires that the death certificate be executed audoris Diabetic Keto attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown encephalopathy Lache 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No ty provolemio autopsy performe 21 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

SHRI KANNAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

7503

Medical

(Check only one)

JAN 0 9

29b. Signature and title of certifier

V. Kerman

SURRATIS

29c. License number

D63183

ROAD

29d. Date signed (Month, Day, Year)

CLINTON -

MD 20735

		1	For State Registrar	State o	f Mary	land		rtment tificate			and M	ental Hyg	jiene eg. No.	008	01660
Phys	iciar		I. Decedent's Name (First, Middle, La									2. Date of Dea Month	Day	Year	3. Time of Death
/Me	dica		Magesie Vivian Ri					4h City	Fown or	Location of	of Death	01	05 4c. Co	2008 ounty of Deat	1:45 P. M
Exan	nine		Long View Nursing		noer)			Mano			or Dodin		l l	rroll	
Funer			5. Social Security Number 6. S 213–12–2982	6өх 1□М 2 ∑ Г		n yrs. Ia 87	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 06/10/1	Year) 1920		hplace (State or Foreign untry) yland
pu *		1-	Usual Residence of Decedent 10a. State 10b. County		10	c. City.	Town or Loc	cation							10d. Inside City Limits
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Baltimore, Maryland 21215-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importment of Health and Mental Hyglene. Importment: If item 27 is marked other than "neturel", or items 23s or 28s-f show eny Injury or other treumatic event, the Madical Examination to anothlised.	Ĺ	by runeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 Yes If Yes, Gir Year or D	rces? 2XINo	r in U.S		Yes, spec		Specify:		ecify Yes or No- Rican, etc.)		Black, White	
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VIAND Suid be file Mental Hy arked other atic event,		e a	17. Father's Name (First, Middle, Last									(First, Middle, Nunn	Maiden St	ımame)	
ryia hould d Mer marke matic		<u> </u>	Harry A. Skidmor				19b. Mailin	g Address	(Street a			i Route Numbe	r, City or T	own, State, 2	Zip Code)
Mar nd 2 sh alth and 27 ts m		1	Randy Richardson									ourg, Ma			
Baltimore , permit. Pages 1 a Depertment of Healmportant: If Item only injury or othe			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 [Removal from			ace of Dispo					Date		tion - City or	
ti Pag ti Pag timent tant: I			4 ☐ Donation 5 ☐ Other (Speci	ty)	1	Mt.	Paran		_		1/8/2				wn, MD
Depending	buce		21. Signature of Funeral Service Lice			MO14	190 _{Ma}	in St	reet	Hamp	pstea	ad, Mary	land		934 South
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dS, P. uires that I signed by Id be deta		<u>a</u>	Part II. Other significant conditions	contributing to o	leath but n	not resu	ilting in the u	nderlying o	ause give	en in Part	l.		obacco use /es 2 🗗	_	o the cause of death?
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la			John W. IV	und	itn	-	MD		12	-3 Y	40)	1/7/	200	5
M			30. Name and address of person who	o completed cau	ise of deal	th (Item スプ	23a) (Type, ろフル	Cotrat	4 0	tred	t, .	min	eles	ten 1	8 ND 2/182
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Southern Maryland Hospital Clinton Prince Georges Section Prince G							anuary		11:05 a ^M
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANDREW 2008 anuary 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Nov. 7, 195 Birthplace (State or Foreign Country) **Funeral** Months Days 1 🔯 M 2 🗆 F 216-80-8730 49 West Virginia Director 1958 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Directo Penna. Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10033 Jasper Drive USA 17225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married 21215-0036 white 1 ☐ Yes 2 🖾 No 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) draftsman Pages 1 and 2 should be filed nent of Health and Mental Hygi injury or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde William South Mary Grace Miller and l 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any injury or other trau Kathy L. South - wife 10033 Jasper Dr., Greencastle, Pennsylvania 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 1/14/08 Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Patic Failure minent **Physician** 12 days /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2000 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1-Inpatient မ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58853 HABIB A CHOTANI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E ANTIETAM ST MD 21740 HAGERSTOWN, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend #29d per PHYS 01-11-2008 CNM
PROGRAM
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day 10:20 P M Eleanor Ann Stephen January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7502 Woodville Road Frederick 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Director 215-20-6345 81 July 1, 1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at Items 23a or 28a-f sh ner must be notified 1 ☐ Yes 2 ☑ No Director Maryland Frederick Mt. Airv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7502 Woodville Road 21771 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: 2 3 ☐ Widowed 4 ☑ Divorced Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Aide U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Anthony Gerdeman Eleanor Hannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important; If item 27 is any injury or other trauonce. Jeanne M. Ashman / Daughter 7502 Woodville Road Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State January 4 □ Donation 5 □ Other (Specify) 2008 Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility
Stauffer Funeral Homes, P.A.
8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 romplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final cirrhosis Physician disease or condition resulting in death) /Medical Examiner biling enhosis Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 1□ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Discrete funeral director. Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specity) Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ₽ ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of ceat 29d. Date signed (Month, Day, Year) 8, 2008 B48181567 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 310 W. 9TH ST PREDERICK MD 31. Date filed (Month, Day, Year) State JAN 1 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Tekla Stakis 9:50am^M 1/4/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8 Fisk Circle Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 5. Social Security Number 218-34-7669 6. Sex 7. Age (In yrs. last birthday) 91 yrs. B. Date of Birth Month, Day, Year 7/17/1916 9. Birthplace (State or Foreign **Funeral** 1 M 200 Latvia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland int of health and Mental Hygiene.

If if lies Z1 is marked other than "nature". 10a, State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Anne Arundel Annapolis Director 1 □ Yes 3 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8 Fisk Circle 21401 Latvia Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes ৡৣৢৄMo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertulis Elsts Petronella Brigis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Turkopuls Son 8 Fisk Circle Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of HImportant: If iter
any Injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1/8/2008 Baltimore, MD 21. Signature of Funda Septe Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 0 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA years /Medical Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse mence of attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) hed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OSTEOPOROSIS 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed HYPOTHYROIDLS M 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar

31. Date filed (Month, Day, Year) JAN 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 MD 888 BESTGATE RD ANNAPOLIS MD 21401
32. Phistrar's Signature

March & Locale

ORIGINAL

Division or Vital Records, P.O. Box 68760,

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CH		30. Name and address of person who completed cause of death Refer to the person who completed cause of death Refer to the person who completed cause of death Refer to the person who completed cause of death	Signature	AMC	Amu	epiles	Mel 2	1401				
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tanley Serwatka	State of Maryland / Department of Health and Mental Hygiene	
tarnoy co. mana	1- For State Certificate of Death	2008 0166
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Medical Examine	er Stanley Joseph Serwatka II - January 13, 2008	21331115
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Anne Al	
	339 Clairbonie Noad	
Funeral Director	Months Days Hours Min. 7 12 10 11	Foreign Country) Florida
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2121 2121 Mental F Marked marked c event, 1	PETGYTIGHU SELWACKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To	wn State Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Finneral Director	Julie Wade/ Sister 339 Claiborne Road Pasadena, Mary	
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Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		rk Fineral Home
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Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. Alcohol and Oxycodone Intoxication	between Onset and
/Medical	Immediate Cause (Final disease a. Camplicating Myocardial Fibrosis	Death
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isic	Investigation Found 1/13/08 Found 9:20 pm Unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Num	nber or Rural Route Number, City
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Hospi 24 hou Funer stely fi		ner as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the build had a provided by the funeral director, page 2 should be detached for use as the build had a provided by the funeral director.	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	
F > F 0	OCME.	gned (Month, Day, Year)
	Thoday W. Te of Thymas) O.C.IVI.E. Sandary	17, 2000
	30. Name and address of person who compléted cose of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Staf	31 Date filed (Month Day Year) 32 Registrar's Signature	
Stat Registra	1851 1 0 2000 Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Louise Bruce Sunderland Рм 2008 January 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 559-14-7630 96 **Director** Dec. 19, 1911 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2xxxNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 2302 River Crescent Drive U.S.A. 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2XXXVo 3altimore, Maryland 21215-0036 1 ☐ Yes **2CX**No Specify þ White 3XXVidowed 4 ☐ Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Kindergarten Teacher Education marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic evenoce. Bryson Bruce Louise Downs ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Sunderland/son 416 10th St., SE Washington, DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Baltimore Crematory 1/5/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 019857 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a nonsequence of): if a y, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred Certification: 12 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 3□ Suicide

Registrar DHMH 17 Rev 1/2001 4 ☐ Homicide

(Check only one)

avI 31. Date filed (Monti

29b. Signature and title of certifier

30. Name and address of person,

29a. Certifier

Medical

State

**Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and

JAN 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

certifier



medical resident

DHMH 17 Rev 1/2001

29c. License number

RESOOI

29d. Date signed (Month, Day, Year)

4,

2008

		4	For	State of Mary		epartment of I Certificate of			- U U U	3 01669
	_		State Registrar 1. Decedent's Name (First, Middle, Las.	Death	2. Date of Dea	leg. No.	3. Time of Death			
	Physicia /Medic	an al	Eleanor	UTEIZI	ner		Month	84 88	7 1715 PM	
7	Examin	er	4 Facility Name (If not institution, give	street and number)	h C	R 4b. City, Town	urll	4c. County of Dea	1 .	
	Comment		5. Social Security Number 6. Se	7. Age (III	n yrs. last birtl	nday) If Under 1 Year	ff Under 24 Hrs.	8. Daje of Birth		nthplace (State or Foreign ountry)
	Funeral Director		127-09-9369	□M 201F 88	١	rs. Months Days	Hours Min.	4/29/19	19 Ne	ew York
	p a		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	Aaryla Febo	5	Maryland Wicomic		Salish					1 ∑ Yes 2 □ No
	286-	Director	10e. Street and Number	30	Darrox	10f. Zip Code			10g. Citizen of What C	country?
	h with	a O	200 Sheffield Ave	э.		2180	4		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f show importent: if Item 27 is marked other than "natural", or Iteme 23a or 28e-f show simply njury or other traumatic event, it a Medical Exercitar must be inclified at an ODGs.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No tf Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of ff Yes, specify Cub 1 ☐ Yes 2 No		pecify Yes or No- Rican, etc.)	0	
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21	ithin ne.	mple	Efementary/Secondary (0-12)	Colfege (1-4or 5+)		life. DO NOT use retire	ed)		-7	1
2	Hygie Hygie Ather t	CO	17. Father's Name (First, Middle, Last)	2 1/2	se	cretary/boc		ne (First, Middle,	clerica. Maiden Sumame)	<u> </u>
ano	Mental Mental Marked o	To Be	Samuel Wolters				Albert	a Hutter	£	
Maryland	2 should be fitted within and Mental Hygiene. Is marked other than aumatic event, the Mi	-	19a. Informant's Name/Relationship (7	ype, Print)		Mailing Address (Stree				
	s 1 and 2 of Health a ltem 27 is		Diane Stelzner/d				or Bridge			le, MD 21035
Baltimore,	Pages 1 ment of He ent: If Iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemeter	Disposition (Name of y, crematory or other pla srael Ceme	tery 1/7,		Salisbury	, MD
Balt	permit. Page Depertment of importent: If eny Injury or		21. Signature of Funeral Service Licen	Nome Professional Association Salisbury, MD 21804						
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	ofications that caused the	e death. Do r	ot enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence	of):				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence	of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
ó,	cate be executed physicien end ; the burial-transit	Exa	resulting in death) Last	Due to (or as a c	onsequence	of):				
8760,	cate b	dical	•	d						
O. Box 6	death certifi e ettending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of o Month	lelivery Day Year
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rds	w requires been sign should be	ed b						101	Yes 2□No 3□	Probably 4 ZUnknown
Division of Vital Records,	elaw hasb	Completed						24a. Was autor perfo 1 🗆 Yes	osy prior t	autopsy findings available o completion of cause of ? es 2 \(\text{No} \)
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hh-li			26. Place of Dea	ath (Check only o	one)	
of \		2	1 ☐ Yes 2 ☑ No 27. Manger of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Ou	tpatient 3 DOA	4 Nursing F		dence 6 Other (S)	pecify)
Ü	ding h. h. After funer	tion	1 ☑Naturaf 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear)	n _i ury W	ork? ⊒Yes 2 □No			
Visi	Atten r deat ector: by the	Ifica	3 Suicide 6 Could not b		- At home, fa	rm, street, factory, office	3	28f. Location (Street and Number or	Rural Route Number,
ă	s efte el Dir	Certification:	4 Hottlicide	building, etc.	Specify)			0, 5	, 0.0.0,	
	To the Hospital or Attending Phys within 24 hours etter death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of one of the basis of example of the basis of example of the basis of example of the basis of the ba	xamination an	e, death occurred at the d/or investigation, in my	time, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manner date and place, and o	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		4.5		nse number		29d. Date signed (Mo	
	1250		V	ama	MY		63991		1-7-2	2008
_	U		30. Name and address of person who ANUPAMA VAR	ADARAJA	IN, 16	+15 SDUT	H DIVIS	SIDN ST	, SUITE B	SALISBURY
	St. Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 8	2008 32. Registrar's	s Signature	Soule				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Janice Lanelle Stanley 2000 AM 08 01 07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice

5. Social Security Number Salisburg At the Lake If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Hours Months Days 1 □ M 2 🔀 F 245-28-8204 79 2/9/1928 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 Tressler Drive 21801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin H. Stanley Grace V. Wilhelm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 501 Tressler Dr., Salisbury, MD 21801 Joyce Alexander/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gilead ARP Church 1/10/08 Huntersville, NC 4 Donation 5 Other (Specify 21. Signature of Fuperal Service Li 22, Name and Address of Facility Holloway Funeral Home Professional Association Kell fl 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE HYPERTROPHIC CARDIOMYOPATHY Due to (or as a consequence of): CONGRSTIUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): OBS TRUCTION INTESTINAL Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA . Manner of Death 1 ☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician /Medical Examiner Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

27 is marked other than "natu traumatic event, the Medical

1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23s

Maryland 21215-0036

Baltimore,

Box 68760,

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funeral director, After this hours after death. uneral Director: / the

Physician/Medical Completed by Be Certification: To

To the Hospital of within 24 hours af To the Funeral D $\mathcal{A}_{\mathcal{O}}$

filled in by

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

0005 8410

1-7-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAVISBURY UP 21802 Q.O BOX 1733 WARLS CHUCAM COASTAL HOSPICA

31. Date filed (Month, Day, Year 2008

29a, Certifier

(Check only one)

29b. Signature and title of certific

32. Registrar's Signature

		-	For State Registrar	State of Maryland	d / Depa		t of H	ealth a		ntal Hyg	giene Reg. No.	008	01671
	52	1922	1. Decedent's Name (First, Middle, Last	1)					2.	Date of Dea Month		_ Year	3. Time of Death
	Physicia		Mildred	Steele					J	an.	7, Day 20	08	11:20P M
	/Medic	_	4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of	Death		4c. Co	unty of Death	1
100	Examin	er	National Luth				Ro	ockvi	lle		Mon	tgome	ery
april 1			Social Security Number 6. Se		ast birthday)		r 1 Year	If Under 2	4 Hrs. 8.	Date of Birt (Month, Da)	h Vaarl	9. Birth	nplace (State or Foreign intry)
	Funeral Director			□M 2XF 101	Yrs.	Months	Days	Hours	Min.	(Month, Da)	28.19	06 Ma	ryland
	7	1	Usual Residence of Decedent							COUL			
	land		10a. State 10b. County	10c. City	, Town or Lo								10d. Inside City Limits
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	288 288	Director	10e. Street and Number			10f. Zij	p Code				10g. Citizen	of What Co	untry?
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	eath	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Dece	dent of H	ispanic Orig	in? (Specif	y Yes or No- can, etc.)	- 14.	Race - Ame	
	ter d	5	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No					, Puerto Hic	can, etc.)		Black, White	nite
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an	od be	Be C	Oscar McDani	el				N	Mary	Dorma	a m		
>	2 should be filed within " n and Mental Hygiene." r is marked other than " reumatic event, the Mac	ို	19a, Informant's Name/Relationship (7	Type Print)	19b. Mail	ina Addres	s (Street	and Numbe	r or Rural F	Route Numbe	er, City or To	own, State, Z	Zip Code)
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	1 and 2 Health tem 27 other tra		20a. Method of Disposition	20b. P	lace of Disp	osition (Na	me of		Dat			tion - City or	
Ö	t of the or o		1 XBurial 2 ☐ Cremation 3 ☐	Hemoval from State Par!	emetery, cre €WOOd	matory or Cen	other plac 1ete:	rv]	/11/	2008	Balt	imor	e,Md.
Ë	Pa tmen tant:		4 □Donation 5 □Other (Specify	")									
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other 2008.		21. Signature of Funeral Service Licen		2			ss of Facilit). ZZ				Ave.,NW
ш.	gomad			on			_		Wa	shin	gton,	DC	Approximate
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. A LZ H C I Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	FIG	3005						Interval Between Onset and Death
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Re	The law ate has b page 2 s	Ę									smed?	death?	
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Division of Vital Records,	or At	Certification;	4 Homicide determined	building, etc. (Specif	y)	ireer, racio	лу, опісе			City or To	wn, State)		
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	ie Hospital or Attendin 24 hours after death. e Funeral Director: Att	Medical	(Check only 2 Medical Exar	nysician: To the best of my kno miner: On the basis of examina	wiedge, dea ition and/or	nvestigation	od at the ti on, in my o	me, date ar opinion, dea	nd piace, ar ath occurre	d at the time	date and p	lace, and du	e to the cause(s)
_	To the Hos within 24 hr To the Fur completely	led	one)	and manner stated.		1 2	Oo Lionn	se number			29d Date	signed (Mon	th, Day, Year)
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	-		> Merce A	uly 410			100	5115	8		ンカルレ	Ary	8, 2008
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	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	Social Control	Di							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Vear Charles S. 7, 2008 /Medical Seay 0106 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cheverly
Order 1 Year | If Under 24 Hrs. Prince George's Hospital Prince George's Funeral 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□F Months Hours Director 225-20-7321 84 Sept 27, 1923 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural" or items 23a or 28a-f show traumetic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 913 - 52nd St, NE 20019 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black. þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) be filed within 7: al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Printer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill thent of Health and Mental Hitant: If item 27 is marked oth Be Southall Seay Willie Harris ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is eny injury or other trai Thelma Seay - Wife 913 -52nd St., NE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery Jan 12, 2008 Suitland, MD 21. Sign ture of Funeral S vice License -22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition a. Cardiac Arrhythmia Approximate Interval Between Onset and Death **Physician** 12 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Atherosclerotic Cardio Vascular Disease 10 years Completed by Physician/Medical Examiner Iding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Lung Disease 15 years resulting in death) Last Due to (or as a consequence of) IF FEMALE: nse 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Yes 2 🙀 No 1 🔀 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zu Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760.

Division of Vital Records,

31. Date filed (Month, Day Year)

29b. Signature and title of certifier.

Revathy Murthy 3001 Hospital Drive Cheverly, MD 20785 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

29d. Date signed (Mgnth, Day, Year)

			1 - For State Registrar	State of Mary		oartmer e <i>rtificat</i>				lygien Reg. N	ZUU0	01673
			Decedent's Name (First, Middle, Last)						2. Date of	Death		3. Time of Death
3	Physici /Medic		Helen Louise	Sanders					Janua		4^{pay} 2008	7:10 A M
7	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location			c. County of Dea	
			St. Catherine's	Nursing	Center	Emmi	tsb	urg		I	Frederi	ck
	Funeral		5. Social Security Number 6. Sex	IM ODE	yrs. last birthda	y) If Under Months	1 Year Days	If Under Hours	Min. (Month.	Dav. Yea	9. Bin	thplace (State or Foreign ountry)
	Director		213 20 3003	M 2XF	99 Yrs.			110010	Dec. 19	, 1	908 Mai	ryľand
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location						10d. Inside City Limits
	Marylan f show	ō	MD Frederi	1	Emmit		~					1 ☐ Yes 2 ☑ No
	the t	Director	10e. Street and Number			10f. Zip				10g C	Citizen of What Co	41
	s with		17504 Tract Roa	ad			2172	27			J.S.A.	
	death ms 2	Funeral	· · · · · · · · · · · · · · · · · · ·	12. Was Decedent Ever	in U.S. 13				gin? (Specify Yes or , Puerto Rican, etc.)	1	14. Race - Ame	erican Indian,
9	after or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No					i, Puerto Rican, etc.)		Black, Whit	
203	ours	d by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 K I No	Specify:			Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, Ire Medical Exertiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Gis	edent's Usua e kind of wo	rk done d	turina mos	t of working	16b.	Kind of Business	/Industry
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22	filed v Hygie ther t		17. Father's Name (First, Middle, Last)		Но	memak	er	10 Matha	or's Name (First, Midd		vn Home	
and		Be		P. Keepe	rs		1		ouise O'			
Maryland	2 should be and Mental is marked (aumatic ev	ြ	19a. Informant's Name/Relationship (Typ	a Print)	19h Ma	ling Address	(Street s		or or Rural Route Nur			Zin Codo)
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ē,	os 1 ar of Hea item	3 8	20a. Method of Disposition		0b. Place of Dis			1	D .		Location - City or	
9	Pages nent of I ant: if its arry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	Jinovai noin State	uth Ca:				1/5/08	Win	ifield,	MD
Baltimore,	그 본 원 중 .	1	21. Sinnature of Funeral Service License			22. Name an	d Addres	s of Facilit	v		•	
m	permi Depar Impo any ir once.	0	Aprilia R. Du	M Court	01191	Myers 210 w	-Dui	rbora	aw Funera St. Emmi	al H	Home, P	.A.
		1	23a. Parl1. Enter the disease, or complied shock, or heart failure. List only on	cations that caused the	death. Do not e	nter the mod	e of dying	g, such as	cardiac or respiratory	arrest,	irg, MD	21727 Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1 00-	nidel	1	1101	1.1.	Datto	. 3	Thata	Onset and Death
В	/Medical		resulting in death)	out to or as a con		120		~~	any oc	1	1) repu	10075
	Examiner		Sequentially list conditions.	telip	heral	10	KC	bla	elds-	201	1	104rs
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as con	nsequence of):	200						170 .00
	and I-tran	хап	that initiated events c.	Due to logas a co	- LUC	3101					-	50410
8760,	cate be executed physician and the burial-transit	aiE		200 /2 (3/400 4 00)	naoquorica or).							
687	ficate phys s the	edical	d									
Box	The law requires that the death certific at the has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr							23d. Date of del	livary
	death e atte d for	cia	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 ☐ 4 Pregnant at time		□Ectopic pr □ Other (sp				_	Month	Day Year
Ö.	that the de led by the a detached	hys	9 □ Unknown	9□ Unknown								
S,	res tha igned be det	oy P	Part II. Other significant conditions con	tributing to death but no	t resulting in the	underlying c	ause give	n in Part I.	23e. Die	tobacco	use contribute to	the cause of death?
ğ	w require been sig should b	ed	Mati vess	el Cor	ona	7 11	1/8	ryo	L. Searly]Yes 2	2 1 No 3□ Pr	robably 4 □Unknown
Records,	e law re has be je 2 sh	ple	<u> </u>			/			24a. Wt	as an topsy	24b. Were au	utopsy findings available completion of cause of
		P S							pe 1 □ Yes	rformed?	death?	
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death Check onl			
	Physic this c	2	1 ☐ Yes 2 XNo		2 ER/Outpatio		-	Nu.	rsing Home 5 🗆 Re	sidence	6 Other (Spec	cify)
Division of	Attending Physician: The la sr death. sector: After this certificate has by the funeral director, page 2	io io	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury		8c. Injury Work	.?	28d. Describ	e how inji	ury occurred	
S	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home form a	M		′es 2⊡1		(Stroot a	and Number or D	ural Route Number.
<u>≥</u>	after Direct	Certification:	4 Homicide determined	building, etc. (S)	pecify)	ileei, laciory	, onice			own, Star		arar noble reuriber,
	spita nours neral		29a. Certifier Certifying Phys	cien: To the best of my	knowledge, dea	th occurred	at the tim	e, date and	d place, and due to th	e cause(s) and manner as	s stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medicel Examin one)	er: On the basis of examend manner stated.	mination and/or i	nvestigation,	in my op	inion, deat	h occurred at the time	e, date ar	nd place, and due	to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier		0 +	29c	. License	number	(107 h	29d. Da	ate signed (Monti	/
	2		Soutal Kh	ampel-	1040	200	17	ب دین	40 >7	01		2008
\wedge	39	,	30. Name and address of person who cor	npleted cause of death	(Item 23a) (Type	, Print)		12	1-123	lus	237-11	cain ST
	2		31. Date filed (Month, Day, Year)	32. Begistrar's S	10/C/	IER	NC	: 1-2	m. 75	beck	S. Me	D2(72)
	Stat	2.		08 Alegera	31101010	1 .0						•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Calvin \mathbf{E} 6,2008 5:00 p Shubrooks Sr. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayside Nursing Center Great Mills Marys If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2□ F Yrs. 212-72-3450 51 07/9/1956 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Great Mills Maryland St. Marys 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number "natural", or items 23a or dical Examiner must be 20634 21376 Lexington Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Mechanic Self-Emploved 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jury or other traumatic event once. James E Shubrooks Sr. Mary Fenwick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) DeAnna Thomas/Daughter 22263 Scott Circle Lexington Park, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial 1/12/08 Leonardtown, Maryland 22. Name and Address of Facility Adams Funeral Home PA 21. Signature of Funeral Service Licenses 20605 Aguasco Rd. Aguasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only or ensure on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusy to for Examine that the death certificate be executed Due to (or as a consequence of) burial-Box 68760. physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificate ! 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: stely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

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State Registrar 30. Name and addre

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31. Date filed (Month

of person who comple

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Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Frances , 2008 Margaret Shymansky January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Medical Worles Date of Birth (Month, Day, Year) yrs. last birthday 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1□M 2፟M F Hours Days Min. 217-18-2465 88 Director 22, 1919 June Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State Show 10d. Inside City Limits notified at Director 1 ☐ Yes 2 ☑ No MD 28a-f Charles Cobb Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be a 16547 Oakley Drive 20625 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: <u>^</u> Specify. White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Post Office Postmaster permit. Pages 1 and 2 should be filed very perartment of Health and Mental Hygis Important: If item 27 is marked other it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Spalding Mary Violet Tippett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Shymansky/Daughter P.O. Box 280, Cobb Island, MD 20625 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Ghost Cemetery 1/10/2008 4 □ Donation 5 □ Other (Specify) Issue, Maryland M00945 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. an. wz Mary's Ave. La Plata MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CAS E /Medical Que to (or as a consequence of) Examiner RUBABLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed BROW BROW and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical MB OC the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page perforn certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 Inpatient 2 ER/Outpatient 3 □ DOA P this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 ☐ Pending investigation Year! 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 20 nerand address of be son who completed cause of death (Item 23a) (Type, 150 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Q	100	œ.	Decedent's Name (First, Middle, Last)				2. Date of Death 2 3 Jime of Death							
e di	Physici /Medio		James A. Smith	J	anuary 3	3, 2008 Year	7:45 PM							
	Examir		4a. Facility Name (If not institution, give street and number	∍ <i>r</i>)		r Location of Death		4c. County of Death						
			8510 Topaz Court 5. Social Security Number 6. Sex 7.	A so the two took highle do.	Clint) If Under 1 Year		Data of Dist	Prince G						
	Funeral Director		5. Social Security Number 6. Sex 1 宮 M 2 日 F 7. Usual Residence of Decedent	Age (In yrs. last birthday, 71 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Yeec. 15,	1936 Ten	place (State or Foreign ntry) nessee					
	yland now at		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits					
	e Ma Ba-f s etifled	Funeral Director	Maryland Prince George's	Clint	on				1X∐Yes 2 □ No					
	with th	Dire	10e. Street and Number 8510 Topaz Court		10f. Zip Code			Citizen of What Cou	•					
	leath ins 233	eral	11. Marital Status 12. Was Decede	ent Ever in U.S. 13.	20735			nited Sta	can Indian.					
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	Armed Force 1 □ Never Married 2 ☑ Married 1 ☑ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced Armed Force 1 ☒ Yes 2 If Yes, Give Year or Date	□No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Specit an, Mexican, Puerto Ric Specify:	can, etc.)	Black, White	frican erican					
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Baltimore, Maryland 21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-40	or 5+)	DO NOT use retired urity Mana			Governme	ant					
102	il Hyg other ent, t	Be C	17. Father's Name (First, Middle, Last)		arre) nan	18. Mother's Name (F	irst, Middle, Mai							
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lan)	2 sho n and l is ma rauma	0.2	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street	and Number or Rural F	Route Number, C	ity or Town, State, Zi	o Code)					
e,	1 and Health em 27 ther t		Myra Banks-Smith - Wife 20a. Method of Disposition	8510	Topaz Con	urt Clintor		735 c. Location - City or T	Over Chata					
nor	ages ent of t: If it		12☑Burial 2 ☐Cremation 3 ☐Removal from Sta	ue i	osition (Name of ematory or other place	tery Jan 10		Brentwoo						
Ħ	nit. Partme ortan Injur	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service License			ss of Facility Stev			· · · · · · · · · · · · · · · · · · ·					
<u>~</u>	Der Imp any	W J	Ahm M. Dow	- A - A - A - A - A - A - A - A - A - A		ing Road, N			10.4					
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Complex and Disease of the cardiac or respiratory arrest, shock or heart failure.											
1	Physician /Medical			l Bowel Card	cinoma				Onset and Death Years					
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68760,	tificate g phys as the	edical	d											
Vital Records, P.O. Box	ath cer attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 20□ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown											
<u>P</u>	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant conditions contributing to death	but not resulting in the u	underlying cause give	en in Part I	23e Did tobac	co use contribute to	the cause of death?					
ords,	w requires to been signer should be	ted by							bably 4 ☐Unknown					
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	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		nt 3 DOA Otho	26. Place of Death (C								
ō	Phys er this eral dir	. To	27. Manner of Death 28a. Date of I	atient 2 ER/Outpatien	IK OLI BOX	4 Linursing Home	5 XResidence 1. Describe how i	e 6 Other (Speci	fy)					
on	Attending Physician: r death. ector: After this certific by the funeral director,	atior	1X Natural 5 Pending (Month, I 2 Accident investigation	Day Year) Injury		k? Yes 2 □ No		.,,						
Division or	al or Attend s after death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building,	injury - At home, farm, str etc. (Specify)	reet, factory, office	28f	Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,					
	ne Hospital or A n 24 hours after one Funeral Direct bletely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the besigned panner. On the basis and panner.	s of examination and/or in	th occurred at the tin	me, date and place, and pinion, death occurred	d due to the caus at the time, date	e(s) and manner as a	stated. to the cause(s)					
	To the I within 2: To the I complet	Me	29b. Signature and infe of certifier	1.0	29c. License		29d.	Date signed (Month,	Day, Year)					
_	(1)		I can fulin	40	14	7 32864	3	January 10	, 2008					
12	19		30. Name and address of person who completed cause of Ari D. Fishman, M.D. 214	1 K Street,	NW #707	Washington	, DC 200	037						
	Sta Registr	te ar	JAN 1 0 2008	strar's Signature										

			1 - For State Registrar		Maryland /		artmen rtificate				F	eg. Ne-	008	01677
	Physici	an	Decedent's Name (First, Middle, Last	")							2. Date of Dea Month	th Day	Year	3. Time of Death
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	show	_	10a. State 10b. County		10c. City, To									10d. Inside City Limits
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93	72 hours after death with the Maryland natural', or items 23a or 28a-1 show deat Ezand'ar must be notified at	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	No.	Specify:			S	pecify: Wh	nite
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21		mp.	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT us	e retired)		9		-	
'n	filed within Hygiene. other then		8th 17. Father's Name (First, Middle, Last)			S	eams	tre		or's Nome	e (First, Middle,	Maida- C	Pvt.	
Maryland 21215-0036	o g a p	Be C	George Spangler								a Smitl		imame)	
2	d 2 should by the and Menta 7 is marked traumatic ex	ဥ	19a. Informant's Name/Relationship (T)		1	9b. Mailin	na Address	(Street a			al Route Number		own. State.	Zip Code)
	nd 2 alth a 27 ls r tra		David Toms/Son								Smithsl	40		21783
e,	of Healt filtem 2 r other		20a. Method of Disposition		20b. Place	of Dispo		ne of					*	Town, State
<u><u>E</u></u>	n 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Howai School	rd U	nive f Me	rsi	ty ine	1/6	/08	Was	hingt	on, DC
Baltimore,	permit. Par Depertment Important: any Injury once.		21. Signature of Funeral Service Licens	⊕ ⊕		22	. Name an	d Addres	s of Facilit	y Au	stin Ro	yst	er Fu	neral Home
ш	20519		1500		>	The Control of the Co							.ngto	n, DC 2001
			23a. Part I. Enter the disease, or comp shock, or heart failure. List only o	lications that caus ne cause on eacl	sed the death. D h line.	o not enti	er the mode	of dying	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
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9 ×	death certifica e attending ph of for use as th	Mec	IF FEMALE:	220 14										
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T	The law requires that the ste has been signed by th page 2 should be detache	by PI	Part II. Dther significant conditions co	ntributing to death	h but not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did to	pacco use	contribute to	o the cause of death?
Records,	w require been sig should b										1 🗆 Y	es 2 🕅	60 3□P	robably 4 Unknown
ပ္ပ	law re as be 2 sho	piet									24a. Was a	n 2	24b. Were a	utopsy findings available
Œ	The ete h	Completed									perform	med?	death?	completion of cause of
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Division of Vital	Physic this c	ည	1 Yes 2 No	lospital: 1 ☐ Inpa 28a. Date of II	atient 2 ER/	_			4		me 5 ☐ Reside			ecify)
G	ding h. After funer	ş	1 Natural 5 ☐ Pending	(Month,	Day Year)	injury	M	Bc. Injury Work	at :? ∕es 2		28d. Describe ho	ow injury o	ccurred	
/isi	Attending ir death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At home,	farm, stre			155		28f. Location (Si	reet and h	√umber or R	ural Route Number.
á	s efte	Certification:	4 Homicide	building,	etc. (Specify)		,				City or Town	n, State)		
	To the Hospital or Attending Physicien: The law within 24 burus eiter death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2 or	edicai (29a. Certifier 1 Vertifying Phy. (Check only 2 Medical Exami	sician: To the be	st of my knowled	lge, death	occurred a	at the tim	e, date an	d place,	and due to the c	ause(s) ar	nd manner a:	s stated.
	the H hin 24 the F nplete	Medi	0110)	and manner	Stateg.									
	5 × × × × × × × × × × × × × × × × × × ×	<	29b. Signature and title of certifier	ATT AS A	- San	do n	29c.	License	number	- 1	2	9d. Date s	igned (Mont	th, Day, Year)
	5							7	175	. /	J	a nuc	Lry 6,	2008
(2)		29b. Signature and title of certifier Cynthology 30. Name and address of person who co Cynthology 31. Date filed (Month, Day, Year)	Sands m	death (Item 23a	a) (Type, ا	Print)	Vurs	ing H	one	, 12+ N	orth	Arti	zan Street
	Sta	te	31. Date filed (Month, Day, Year)	3 Regi	strar's Signature	5500			<u>V.11.</u>	ans	port,	uary	land	21735
	Registr		JAN 0 9 2008	3 Acres	w K	Son	150							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month . Decedent's Name (First, Middle, Last) Year 08 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (If not institution, give street and number) COM Medica Kellonal Birthplace (State or Foreign Country) If Unde Date of Birth (Month, Day, Year) If Under 24 Hrs. 1**0**M 2□F Months Days Ma -10 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 □ No BURY WICOMICO 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Gi 1 ☐ Yes 2 No Specify: Specify: If Yes, Give , Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Worker BeR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) md 21804 Sister Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20b. 20a. Method of Disposition 1 Rurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐ Removatirom State Sharptown, Mo 08 ZION Umc cem. 22 Name and Address of Facility h 13 CINIC SMITH FUNETHE HO f Funeral salisbury mdaissi Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) WP Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 ☐Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 3 No 1☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? injury 1 🔊 Natural

permit. Pages 1 and 2. D. permit. Pages 1 and 2. D. pertment of Health a In ortant; if item 27 is, and injury or other one. Physician /Medical Examiner

item 27 is marked other than "natur other traumatic event, the Medical

: 1 and 2 should be filed within Health and Mental Hygiene.

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

or Attending

Herman

Examiner attending physician and for use as the burial-transit Physician/Medical certificate has been signed by the a rector, page 2 should be detached it Completed by funeral director, Medical Certification: To Be After this after death.

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

1 ☐ Yes 2 ☐ No

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier (Check only

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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and manner stated.

100 E Carroll St. Salisbury P.P.M.C hodn. Dennis 32. Registar's Signature 31. Date filed (Month, Day,

filled in by the

within 24 hours a

To the Funeral I

completely filled

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1/1/2008 UNK CARROLL CHARLES TIEMEYER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 21385 PENNSYLVANIA AVE CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 XM 2 □ F Yrs. 10/09/1919 MD 88 Director 219-01-8611 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 No Director CHESTERTOWN MD KENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 21385 PENNSYLVANIA AVE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No 3altimore, Maryland 21215-0036 Specify Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) item 27 is marked other than LETTER CARRIER POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGUERITE COLLENS FREDERICK T.TIEMEYER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) MEG NEWMAN/NIECE 84 AQUARA DR. JENSEN BEACH, FL. 34957 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Department of Important: if it any injury or conce. 1 ☐ Burial 2 X Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) CHESAPEAKE CREMATION 1/2/2008 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 Kuk 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a considuence of): Examiner 11 ORI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2□No 1 TYes 2 ₪ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 1 TYes ၉ this funeral 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No or as after decrai Director: A investigation Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral (
completely filled) filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01/05/2008 Year 2:00 P M Physician Ralph E. Tavel, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bowie

Finder 1 Year | If Under 24 Hrs. Prince George's 4011 Woodrow Lane 8. Date of Birth 04/03/1928 7. Age (In yrs. last birthday, Social Security Number **Funeral** Months Days Nashville, TN 1 M 2 F 578-30-7940 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Show 7 is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Bowie Director Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20715 USA 4011 Woodrow Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: 3 3 → Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I and 2 should be filed within dealth and Mental Hygiene.
Im 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Private Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olivia Wood Sterlin E. Tavel, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: if item 27 is any injury or other trau 4203 71st Ave., Landover Hills, MD 20784 LaDonna Sulima / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Bunal 2 □ Cremation 3 □ Removal from State 01/10/2008 Davidsonville, MD 4 Donation 5 Dother (Specify) Lakemount Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home mont am 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial infarction Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has birector, page 2 s autopsy performed? 1□ Yes 2- No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? After 5 Pending investigation the Funeral Director: Af 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TECTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01/08/2008 D0014252 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Antonio B. Valentin M.D. 7313 Hanover Pkwy Ste A., Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan		rtment <i>tificate</i>			ınd Mei		giene		01681
	. Physici	9	Registrar 1. Decedent's Name (First, Middle,	Last)	-40)	imoure	0, 0, 0		2.	Date of Dea		y i Year	
	Physici /Medic	ai	Audra (littine	To	m 10	4h City 3	Town or i	Location o		inua	-	County of Dea	
	Examin	er	4a. Facility Name (If not institution, Pleasont Vii	en Nursir	ng H	one	Mt.	Air	()	Death			ARR	
	Funeral		5. Social Security Number		e (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birt (Month, Da ar 2,	h y. Year)	9. Bi	rthplace (State or Foreign Country) St Virginia
H	Director		212–34–4666 Usual Residence of Decedent	101012,221	70	Yrs.				IM	ar Z,	193	/ WE	sc virginia
	ryland how		10a. State 10b. County	-11	10c. City	y, Town or Lo	cation	Mt	. Air	77				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	Director	Maryland Carro)TT			10f, Zip		• 2111	· Y		10a Cil	tizen of What C	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show is Nedical Evar in ar mast be notified at	i Dir	4104 Old Nation	al Pike			101. 210	0006	217	771			USA	,
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Nas Deced f Yes, spec	ent of His	panic Orig	gin? (Specif	y Yes or No an, etc.)		14. Race - Am Black, Wh	
36	s after	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☑ Divorced				1 ☐ Yes 2	⊠ No	Specify:				Specify: V	white
21215-0036	2 hour	ted t	15. Decedent	s Education		16a. Dece	dent's Usua	l Occupa	tion	t of working		16b. K	ind of Busines	s/Industry
2	rithin 7 ne. han "n	Completed	(Specify only highest	College (1-4or	5+)	life.	oo Notus ecret	e retired)	ing most	or monning		Te	lephone	e Company
d 2	Hygier Hygier Sther the	e Co	12 17. Father's Name (First, Middle, L	ast)							irst, Middle,			
<u>ılan</u>	Mental Mental rrked c	To Be	Franklin C.	Maxwell							. Hor			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Exarch Metimatics to colificate in Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical Exarch Medical		19a. Informant's Name/Relationsh Gail Jones, Gu			19b. Mailir 125	ng Address Stone	(Street a	enue,	West	minst	er, City o	or Town, State, MD 211!	Zip Code)
ore,	es 1 and 2 of Health au fitem 27 is rother trau		20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from State	0.6	lace of Dispo	sition (Nan natory or of	e of ther place)	Date			ocation - City	
Baltimore,	tment tant: i		* 4 ☐ Donation 5 ☐ Other (Sp	ecify)		arroll	Crem	ator	Υļ	01/07/			nfield	·
Ba	Depar Depar Impor any in		21. Signature of Funeral Service 1	Surbon		5 "	91 Wi	llis	Stre	Myer eet, W	s-Dur Jestmi	nste	er, MD	ral Home 21157
ŋ	•	1	23a. Part . Enter the disease, or shook, or heart failure. List of	complications that caused only one cause on each li	d the death	h. Do not ent	er the mode	e of dying	, such as	cardiac or re	espiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Au	te	Rana	fa	ilun	ع					5 days
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Ó	ntificat ng phy s as th	Physician/Medical	IF FEMALE:											
Вох	leath certifica attending ph	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pro						23d. Date of d Month	lelivery Day Year
P. O.	the de	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown										
	ires that the death signed by the atter I be detached for u	by P	Part II. Other significant conditio	ns contributing to death b	out not resi	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t		/	to the cause of death? Probably 4 Unknown
ord	w require been sign	eted	Par Jaraba	Colinable	0 210		204	100	~ 110	1	24a. Was		24b. Were	autopsy findings available
Rec	9 4 9	Completed	Jananoia	Seria Zarini		4					auto		prior to death	o completion of cause of
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?							of Death (Check only		J	
of V	dii S	To	1 Yes 2 No 27. Manne of Death	Hospital: 1 Inpati		ER/Outpatier			4 2 110		5 Resi		6 Other (Sp	pecify)
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Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could n 4 Homicide determi		ijury - At ho tc. <i>(Specif</i>	ome, farm, str	reet, factory	, office		28	f. Location (City or To	Street a wn, Stat	nd Number or . (e)	Rural Route Number,
Ω	To the Hospital c within 24 hours af To the Funeral D completely filled in	ai Ce	29a. Certifier 157 Certifyin	g Physician: To the best	of my kno	wledge, deat	h occurred	at the tim	e, date an	id place, and	d due to the	cause(s	and manner	as stated.
	n 24 hos n 24 hos ne Fun oletely	edica	(Check only 2 Medical E	xaminer: On the basis of and manner st	of examina	ition and/or in	vestigation	in my op	inion, dea	th occurred	at the time,	date ar	id place, and d	ue to the cause(s)
	To the To the Complex complex	Σ	29b. Signature and title of certifier	h _				: License	number 3 - 4	69		-	ate signed (Mo	nth, Day, Year)
,	Arga		30 Name and address of passes	who completed cause of	death (Iten	n 23a) (Tvne				,			- (
_	100		N-B VELLANKI,	3850 COLU	MBIA	160	Liken	Jacy	# 3	08,	Co (407	יול י	a, Mi	2(043.
4,	Sta Regist	ate . rar	30. Name and address of person of N-13 VELLANK 1 31. Date filed (Month, Day, Year)	7 2008 32. Regit	rar's Signa	ature	Spare							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 4, 2008 Year **Physician** 4:15a M Wanji Roland D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 9/3/1974 215-71-8842 33 Cameroon Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Ex. miner must be notified at 1 ☐ Yes 2 No Montgomery Germantown MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 20874 Cameroon 18905 Highstream Drive Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 □ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Metro Transit Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pierre Wandji Suzane Nganwa 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health a 9900 Sudan Place Upper Marlboro, Md 20772 Adonis Nseudi/Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
Family Cemetery 1/19/2008
Nkongsamba, Cameroon 20a. Method of Disposition Department of Important: If it any injury or o oţ 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Spegly) PATTEMP AGGESPITMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 MO • Immediate Cause (Final disease or condition resulting in death) Nasopharyngeal Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Metastasis to brain 2 mo. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine executed burial-trar Due to (or as a consequence of) Box 68760. attending physician pe Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. ģ Colitis, Neutropenia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy page 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ပ After this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D65485 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barbara Supanich MD 1500 Forest Glen Rd Silver Spring, Md 20910 Registrar's Signature 31. Date filed (Month, Day, Year, 0 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death January Anne Brown Williams 2008 6:42 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) May 20, 1925 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Days Min. Months Hours 1 ☐ M 2 😿 F 82 420-24-4036 Florida Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Baker Place South, Apt. 11 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ◯ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) (unk.) 17. Father's Name (First, Middle, Last) Henry Carter Brown Cleo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus B. Williams / Husband 1203 Baker Pl. South, Apt. 11, Frederick, MD 21702 20b. Place of Disposition (Name of cematery, crematory or other place) Kestnaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation Jan. 14 3 □Removal from State 4 □ Donation 5 Other (Specify) 2008 Memorial Gardens Frederick, Maryland 21. Signatur of Funeral Sovice Licens Ræsthaven Fuheral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disea shock or heart failu e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Findisease or condition resulting in death) esporator Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myoc Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death Dav 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 1∏ Yes 2 **X** No 25. Was case referred to medical 26. Place of Death (Check only one) ₩ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

show

from "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

filed within 72 hours after death

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than 'any Injury or other traumatic event, the Me

Saltimore, Maryland 21215-0036

Box 68760.

P.O. |

Division or Vital Records,

Hospital or Attending

that the death certificate be executed burial-trar physician the. attending ed by the a detached f signed to peen has page 2 s certificate this After

Examine Physician/Medical à Completed Be ို funeral Certification: ithin 24 hours after death.

the Funeral Director: After other of the fur

27. Manner of Death

1 X Natural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier

one)

Medical

4 Homicide

(Check only

5 ☐ Pending investigation 6 Could not be determined

1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

0035106

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400

31. Date filed (Month, Day,

State Registrar

2

			For State Registrar	State of Ma	aryland		artment of F rtificate of			, ,	ene g. No 200	8	01684	
	Physicia	an	1. Decedent's Name (First, Middle, La.	st)						Date of Death Month		⁄ear	3. Time of Death	
	/Medic			eston						anuary			2:00 P M	
	Examin	er	4a. Facility Name (If not institution, glv				4b. City, Town, or Location of Death 4c. County							
	1-0-		Northampton Mano 5. Social Security Number 6. S		e (In yrs. las	t hirthday)	If Under 1 Year	deric		Date of Birth			erick	
Ė	Funeral Director			M 2 XF	92	Yrs.	Months Days Hours Min. (Month, Day, Year)					9. Birthplace (State or Foreign Country) 1915 Maryland		
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	he Mi 8a-f otifie	Director	Maryland Freder	rick		Free	derick			1.0				
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and and	be fi	8 61	17. Father's Name (First, Middle, Last, Clarence Fox	,					·		laiden Surname)			
Ĕ	12 should be 1 n and Mental I is marked of raumatic eve	5-	19a. Informant's Name/Relationship (Type Print)		10h Mailir	ng Address (Street			Philli		toto Zin	Cadal	
<u>8</u>	id 2 sho Ith and 27 is ma traum:		, ,								-	ate, zip	Code)	
ē,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr.		June Lehrman / Da 20a. Method of Disposition	ugnter	20b. Plac	e of Dispo	59 Bear D sition (Name of matory or other place	en, r	rederi Date		21/01 l0c. Location - C	ity or To	wn, State	
Baltimore,	Pages nent of t int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		. I .		Cemetery		1/12/2	008	Washing	oton	. DC	
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ñ	any per		bustness	Faul	br]]	621 Opos	sumto	wn Pik	e, Fre	derick,	MD	21702	
			23a. Part1. Enter the disease, or com shock, or heart failure List only	plications that caused	the death. I	Do not ent	er the mode of dyir	ng, such as	cardiac or res	spiratory arre	st,	- In	Approximate Interval Between	
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J.	that led by detail		Part II. Other significant conditions of	contributing to death bu	ut not resultin	ng in the u	nderlying cause giv	en in Part I	i.	23e. Did toba	acco use contrib	ute to th	ne cause of death?	
Vital Records,	w requires that been signed to should be deta	d by								1 ☐ Yes	s 211 No 3	☐ Prob	ably 4 Unknown	
ဂ		Completed								24a. Was an	24b. We	ere autor	psy findings available	
Š	sician: The law certificate has b irector, page 2 s	шo								autopsy perform	pri led2 de	or to con ath?	inplication of cause of	
<u>ra</u>	an: tiffica tor, p	BeC	25. Was case referred to medical					26. Place	e of Death (Ch			Yes	2□ No	
	≥ '5 b	To B	examiner? 1 ☐ Yes 2 ☐ ¥6	Hospital: 1 ☐ Inpatie	nt 2□ER	/Outpatier	t 3 DOA Oth			-	nce 6 □Other	(Specify	<i> (</i>)	
	ding Ph .r After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry 28 V Year)	Bb. Time of Injury	28c. Injur Wor				w injury occurred			
<u> </u>	Attending r death. ector: After by the funer	äţ	2 ☐ Accident investigation					Yes 2□	No					
DIVISION	I or Atten after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injubulding, etc	iry - At home c. (Specify)	, farm, str	eet, factory, office			8f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 □ Certifying Ph 2 □ Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	dge, deat and/or in	n occurred at the tir vestigation, in my o	me, date ar opinion, dea	nd place, and ath occurred a	due to the ca it the time, da	use(s) and manr ite and place, an	ner as st id due to	tated. the cause(s)	
	To the complete of the complet	M	29b. Signature and title of sertifier	2008			29c. Licens		00	29	d. Date signed (
		-	Mel		-Al- (1)) -\ (T		6 49	77		1 7-	0		
-	}		30. Name and address of person who					Λ.*.	M	01771				
	Sta	te	Ronald E. Mi. 31. Date filed (Month, Day, Year)	32 Aegistra	ar's Signatur	eTT	Orive, Mt	. Alr	.у, МД	<u> </u>				
	Registr		IAN 1 1 20	32 negistra	w St.	65								
			- Unit			▼								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Emily D. Whyte 1/3/2008 5:15am 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Crofton Convalescent Center Crofton er 1 Year | If Under 24 Hrs. Anne Arundel If Linde 8. Date of Birth (Month, Day, Year) 11/13/1920 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. 1 □ M 2 🖫 F 87 Yrs. 172-18-1920 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes ZNo Anne Arundel Edgewater 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 309 Millswamp RD 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify. Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) IINK Mildred Tolf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Whyte 309 Millswamp Rd. Son Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Indian Town Gap Veteran 1/8/2008 Annville, PA 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Se 7 12 Ridgely Ave. Annapolis, MD 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arling Due to (or Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yo Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No autopsy 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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an "natural", or items 23a or Medical Examiner must be r

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s 1 and 2 should be fil f Health and Mental H tem 27 is marked oth other traumatic even

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr

Pages 1

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifie

4 Homicide

(Check only one)

29b. Signature and title of ce

MD

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-transit physician as 1 attending use ō ed by the a detached f s been signed be should be deta page 2 certificate funeral director. this After

law requires that the death certificate be executed Physiclan: or Attending within 24 hours after death To the Funeral Director: filled in by Hospital completely

Division or Vital Records, P.O. Box 68760.

Medical Certification: To State

CAND Yea 0

2008

5 Pending

investigation

determined

6 Could not be

29c. License number

28c. Injury at Work?

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury

(Month, Day Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28d. Describe how injury occurred

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Carl Wallace ianuan /Medical 2008 4a. Facility Name (If not institution, give street and number) 4h. City Town or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George"s Lanham 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/17/1933 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Hours Months Days Min. 1 X M 2 □ F 578/40/8260 74 Director Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show dk al Ex miner must be notified at Prince George's 1 Yes 2 No Temple Hills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2818 Iverson Street 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (2) Yes 2 □ No If Yes, Give 1955 Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Marýland 21215-0036 1 ☐ Yes 2 No Specify. <u>ک</u> Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Columbus Wallace 0 Helen Epps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aileen Wallace, Wife 2818 Iverson St Temple Hills Md 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 XBurial 2 □ Crent ation 3 Demoval from State Maryland Veterens 1/17/2008 Cheltanham, Md 4 Donation 21. Signature of Funda 22. Name and Address of Facility Taylor's Funeral Home 1722 North Capital St NW Washington DC 23a. Part1. Enter the disease, or com-shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** douge disease or condition resulting in death) TCU /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) by the a TYPS 2 No 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has e 2 certificate ha autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 281 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient this မှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

5

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

ndes

31. Date filed (Month, Day, Year)

JAN 1 0 2008

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

WIL 10

D31666 021 2008 xeus in m mas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONEZ ANTHUR WESTMINSTEN, MARYLAND III m iltzonas K GALVIN 31. Date filed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32. Registrar's Signature

and manner stated.

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12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:37 a^M Wallace January 2008 Mike /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 XM 2 ☐ F Yrs. 6/1/1924 Maryland 83 Director 216-22-3609 Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland 's and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b County ral", or Items 23a or 28a-f show Ex-miner must be notified at 1X Yes 2 No Forestville Director Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20747 3319 Walters Lane Apt. 102 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates:1 9 4 3 − 4 6 1 ☑ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Board of Education Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hawkins Wallace Lucy ٩ Lloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 4 3 19a. Informant's Name/Relationship (Type. Print) Capital Heights, Maryland 1718 Quarter Ave. Wilton Wallace/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tment of F 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Maryland Veterans 1/15/08 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** aspiration PARLMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy atter for u Year Month in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has irector, page 2 performed death? 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes မ 27. Manger of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 ☑ Natural 2 ☐ Accident 5 Pending the Funeral Director: After Action of the Funeral Director: After The Funeral Director of the funeral 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Coylid not b 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical tical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title o 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surta 303 Clinton, Maryland 20735 1501 SURRAHS NO 1021 Road JACQUES CEPHIEIN 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 0 9 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:37 A M DANA **JANUARY** 2008 KEVIN WORRELL 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12303 THOMAS PROSPECT DRIVE PRINCE GEORGE'S BOWIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCH 22 1954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 409-86-6169 Months 1 M 2 □ F TENNÉSSEE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1¥∏Yes 2∏No Director MD PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12303 THOMAS PROSPECT DRIVE 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK Ş. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DOCTOR PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev GWENDOLYN HOCKETT UNKNOWN ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12303 THOMAS PROSPECT DRIVE BOWIE, MARYLAND 20720 WORRELL/WIFE **GWENDOLYN** Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWAY CEMETERY 1/19/2008 KOSCIUSKO, MISSISSIPPI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GLIOBLASTOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as the attending If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 2 No filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2[**X**No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide i 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7 2000 B 08/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONA LESKUSKI M.D. 9200 BASIL COURT # 200 LARGO, MARYLAND 20744 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **5** , **Physician** 2008 8:10A M Agnes N. Wilson Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Prince Georges Clinton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 200 Months Days Hours Min. 03-25-1930 So.Carolina 577-42-6959 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No MD Prince Georges District Heights Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20747 USA 7213 Kipling Parkway by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry <u>Food Preparer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental Health and marked oth Be Rosetta Jackson Leroy Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7213 Kipling Parkway 19a. Informant's Name/Relationship (Type. Print) Frank Wilson, Jr. (Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

District Heights Mary land 20747

20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Resurrection Cem. 01-11-2008 Clinton, MD Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., DC 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20003 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COLONZY7

Due to (or as a consequence of): DI /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed burial-transit and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate Wound 2 No Lh 1 ☐ Yes 1☐ Yes 2 □ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern Ave-SE-DC BoTello M.D. 132 2008 32. Registrar's Signature 3 Date filed (Month, Day, State JAN 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2008 4. 4:50 0. West January Samuel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Davs Hours Min 1₩ M 2□F Director March 14, 1928 Washington, DC 79 578-38-5523 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 11 Yes 2 □ No Director District of Columbia Washington 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2517 Ontario Road, NW 20009 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Black. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3 College (1-4or 5+) Elementary/Secondary (0-12) State Department Supervisor Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela D. Kelly Samuel West, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2517 Ontario Road, NW Washington, DC 20009 Delores Rue-Lynch - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a Method of Disposition Department of important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) Lincoln Memorial Cemt. Jan 19, 2008 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Ent. r the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest Due to (or as a consequence of) Massive Stroke Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Parkinson's Disease Due to (or as a consequence of) Cardiac Arrest Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ∐ Yes 2 √ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No

Physician /Medical Examiner certificate be executed burial-tran the

Box 68760,

P.O. I

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u>

filed within 72 hours after death with the Hygiene.

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Pages 1

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3altimore, Maryland 21215-0036

nding physician use as t atter signed by t d be detach page certificate funeral director, After this

þ

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

6 Could not be determined

Division or Vital Records, after death. vithin 24 hours at

CR (3)	
CR (3)	

Dr. Kanwaljit Nagi 1500 Forest Glen Rd. Silver Spring, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D56063

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 5, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Diana Yolanda Wright January 2, 4:20 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's General Hospital Cheverly If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country)
 New York Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Days 1 □ M 2 3 Yrs. 068-44-7406 57 April 6, 1950 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Prince George's Ft. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8420 Indian Head Highway C-1 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Federal Government Contracts Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clara Smith Anderson Andrew J. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Diana A. King / Daughter 8420 Indian Head Highway C-2 Ft. Washington, Maryland 20744 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 3 Removal from State Calverton National Cem. 1/14/2008 Calverton, New York 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of F eral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Pan1. Enter the disease, or complications that can shock, or heart failure. List only one cause on ea Approximate interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition **Physician** Break disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Septois Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Chest Wall.
Due to (or as a consequence of) and Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 X No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of after death. 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled filled 1: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

CH State

Registrar

30. Name and address of person who

JAN 1 0 2008

pleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician JANUARY** 2008 3:03 JOSEPH WHITE JAMES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1X M 2 7 577-42-9579 1930 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10h County r then "natural", or iteme 23a or 28a-f show the Madical Exeminar most be notified at 1 XYes 2 No PRINCE GEORGE'S MD LANDOVER Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20785 USA 6740 LANDOVER ROAD # 204 death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status filed within 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify BLACK If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ANIMAL CARE TAKER GOVERNMENT 9TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, spire. Be HENRY QUEEN IDA QUEEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2336 ALAVA COURT WALDORF, MARYLAND 20603 LISA RUSSELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 1/12/2008 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) **Examiner** CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in titated events resulting in death) Last Due to (or as a consequence of): Examine HYPERTENSIVE CARDIOVASCULAR DISEASE The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No the 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4X Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2X No 1 Yes 2K No 1 ☐ Yes Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 □ DOA 2X No 1 Inpatient ို 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after e Hospitei o 24 hours af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OOHNELL CUMBERBATCH 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signat State PO NAL Registrar

Box 68760. Division or Vital Records, P.O. or Attending Physician;

Baltimore, Maryland 21215-0036

5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State

Registrar

completely

within 24 hours a To the Funeral

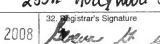
31. Date filed (Month, Day, Year

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29b. Signature and title of certifie

29a. Certifier

(Check only



and manner stated.

cause of geath (Item 23a) (Type Print) Stude 101 fo BOX 838 leonard town, Wed 2065

JAN 07,2008

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** tnderson 2008 7 an enni /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GWYNN Baltmore Minna Dak If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2□ F Days 80 Yrs. Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County Baltimore MD 1 ☐ Yes 2 No Director Cax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or Koad 21207 1123 Minna Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after anti of Health and Mental Hygiene. anti I flem 27 is marked other than "natural", or ite any or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Mamied Black 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bethlehem Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 6th arade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anderson Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Oak MD Anderson Daughter 3 Minna Road Gwynn permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 28/08 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 3 Removal from State torast MISON 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Greene Frunera SVCS Vaughin aughn Green 8728 Liberty Road Rundallstown MD 21133 23a. Part1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** au ct myscar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oronara Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobaeco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 🗆 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home Hospital: 2[7/No ² 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours are:
To the Funeral Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) run 03 32. Registrar's Signature 31. Date filed (Month Day, Year)

State

Registrar

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2008

DHMH 17 Rev 1/2001

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State Registrar

IANUARY

DOROTHY ADOLPHSON

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** JANUARY ALLEN 19 2008 50:18 GEORGE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL THE JUHNS BALTIHORE CITY HOPKING If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year)
1-3-1949 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days Hours Min **X**M 2□ F 421-62-0120 Director 59 Al Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County items 23a or 28a-f show ner must be notified at 1 Yes 2 No Director Mechansville N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with U S 20659 Funeral <u>37548 Cox Court</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner Black 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Unk life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ואס 1 and 2 Siroum. of Health and Mental Hygiene. of Item 27 is marked other than "יי יייי פייפוt, <u>the Med</u> Mirant Power Plant College (1-4or 5+) Elementary/Secondary (0-12) N/A 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Mae Lyles Sherman Allen, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35601 13th Avenue N. W. Decutur, Alabama Reynolds F/H 103 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Decatur, Al 1-26-2008 Sterr's Cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licenses MD 21202 1101 E. North Avene Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 HOURS SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** MONTHS PROSTATE ADENOCARCINOMA METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760%Due to (or as a consequence of): by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation M 1 ☐ Yes 2 ☐ No s after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sanataun RES - 000 JANUARY B MD 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NORTH WOLF STREET MARYLAND 21287 600 PAUN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:00 P M Byron Franklin Archer, Sr. 23, 2008 January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Severn 8300 Jacobs Road Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea If Under 1 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months Hours 1**X** M 2□ F Pennsylvania Jan 18, 1914 Director 94 236-34-8156 Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Maryland| Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or United States 21144 8300 Jacobs Road Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married o, Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3 X Widowed 4 ☐ Divorced Year or Dates "natura!" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Warwood Transfer Truck Driver 10 Department of Health and Mental Hygie Important: if item 27 is marked other i any injury or other traumatic event, <u>tt</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethe1 Sampson Mary ဂ္ John Lynn Archer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vaneesa Manchester/granddaughter 8300 Jacobs Road Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State Mt. Calvary Cemetery 1/27/2008 Wheeling, W Va 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Odenton, Maryland 21113 Honres 1411 Annapolis Road uccint: Approximate Interval Between Onset and Death 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final wars Physician disease or condition resulting in death) avance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Veal in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Mknown 2 No 3 Probably 1 ☐ Yes Completed 24a. Was an autopsy performe 24b Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 **2** No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \subseteq Nursing Home 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 2 27. Manner Death completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Director: After (Month, Day Year) Injury 1 L Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

Signature and title of confifier

31. Date filed (Month, Day, Year)

JAN 25

2008

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Year Month **Physician** 12:30 29 N Bine brink John 541 7003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Parleville Balhane Cronwell (Tenesis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 108M 2□F Yrs Aug 14, 1923 Director 216-20-663 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 27 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, if a Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Daltimore altimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 234 7623 -Ivenue 21 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. illed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse 12 Designer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Brundick Sinebrink lizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other treu QDG. "Bonnie" Binebrink pouse 7623 Daniels Avenue Daltimore MD 21234 20b. Place of Disposition (Name of cometery, crematory or other place). 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1-23-2008 Baltimore Park Cemetery Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Syrs-Parkville
8800 Harford Road Parkville mD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Ca.

Due to (or as a consequence of): **Physician** Cardio myogath years disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, attending physician Physician/Medical the as IF FEMALE esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the. 9 Unknown 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ CAO 1 Yes 2 No 3 Probably 4 Unknown pinous Completed peen C600 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No Adust Failure to Minor 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 | Homicide within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Kley 231798 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 670; N Charles 4>02 KASESZ

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1/19/2008 6:45 A M **Physician** George A. Bower /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Marley Neck Nursing & Rehab Glen Burnie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 87 1XM 2□F Yrs. Virginia 10/1920 230-10-4013 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 7575 E. Howard Street 21060 2 should be filed within 72 hours after death an and Mental Hygiene.
Is marked other than "natural", or items 23; raumatic event, the Medical Examiner must . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married 1 □ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Mechanical Engineer 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Mildred Stiff John Joseph Bower traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ida Virginia Bower / Wife 7575 E. Howard Street, Glen Burnie, MD 21060 if Health if 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages 'Department of HIMPortant: If Ite 1 XBurial 2 □Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) Salem, Virginia 1/23/2008 Sherwood Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Ave., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Houce Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, jate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 2 No 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 1 ☐ Yes Certification: To 28b. Time of funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

In Funeral Director: A sletely filled in by the full of the full 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical To the Hosp within 24 hou To the Fune completely fi 2 Medieal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of

State Registrar 30. Name and address

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Ave

Annapolis

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

100ra MD. 600

2008

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** BUEDEL 09: 30 AM ELMIRA 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKING BAYVIEW MEDICATI CEMBE 8. Date of Birth (Month, Day, Year) March7,1917 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 21 F Days Hours Min. 90 220-07-1594 MD Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 □ Yes 24 □ No MD Baltimore Essex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 7 must be n 313 Eastern Blvd 21221 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 7 is marked other than "natural", or traumatic event, the Medic 4 Exami 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 2 3 □ Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tavern Owner Bar 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Thomas Christina Leineweber ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a E.Christina Buedel /daughter 3719 Clarks Point Road Baltimore MD21220 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō 1 ☑ Burial // 2 ☐ Cremation 3 ☐ Removal from State injury or Department of important: If any injury or Oak Lawn Cemetery 1/23/08 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rame and Address of Facility 300 Mace Ave. Bayto MD Connelly Funeral Home of Essex 21221 21. Signature of Fungral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OCGAN MULTIPLE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner OPEN LEFT TIBLA the burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buria pe Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Dav Vear 5 Other (specify) ☐Yes 2XNo been signed by the a should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24a. Was an page 2 autopsy perform certificate ATRIAL FIBRILLATION 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred After (Month, Day Year) Injury 1 Natural 5 Pending investigation nours after death.
neral Director: Af OLICO PM 1 ☐ Yes 2 No FAU 07 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 313 Enstau Ave, e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Ittle of certified completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 0 4940 EASTERN AVENTE BALTI MORE, gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	ian	1. Decedent's Name (/ Roslie			Bro	odie				2. Date of De Month	Day	2608	3. Time of Deat
/Med Exami		4a. Facility Name (If no	ot institution, give	street and number)			4b. City, Tow			V		inty of Deat	h
		Union Me	emoria]	l Hos			Ba]	Ltimo	re er 24 Hrs.	O Date of Pie		/A	halana (Ctata or For
Funeral Director		5. Social Security Num 230-22-		O	e (<i>In yrs. li</i> 61	ast birthday) _ Yrs.	Months Da			8. Date of Bir (Month, Da 4 - 2 - 3 6	iy, Year)	Co	hplace (State or For untry) FT
de de-		Usual Residence of De											10d. Inside City Lin
how	_		0b. County N / A		1 1	altimo							1 X Yes 2 □
8a-f s	Director	11.0			Б	arcinc		<u> </u>			10g. Citizen	of What Co	untry?
penflit. Tages I and a Sanda General minimum penglish and management of the sanda may be management. If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at mone.	Dire	10e. Street and Numb		9			10f. Zip Cod 2121				Tog. Citizen	US.	
ms 23	Funeral	11. Marital Status		12. Was Decedent		S. 13. W	as Decedent	of Hispanic	Origin? (Sp	pecify Yes or No Rican, etc.)	D- 14. F	Race - Ame Black, White	rican Indian,
or ite	교	1 Never Married	2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give			Tes, specily (☐ Yes 2√2			nican, etc.)	Sne	Afri	
ral", c	l by	3 ∰Widowed 4	Divorced	Year or Dates:			•		·y·		ope	Amer	
natu	etec	1: (Specify	 Decedent's Education of the control of th	lucation ade completed)		(Give k	ent's Usual Oc ind of work do O NOT use re	one durina m	ost of wor	king	16b. Kind o	of Business/	Industry
than than	Completed	Elementary/Second	lary (0-12)	College (1-4or !	5+)		ousew:	_ ′				Sel	f
Hygiene other than		17. Father's Name (Fi	irst, Middle, Last))		<u> </u>		18. Mo	ther's Nam	ne (First, Middle	, Maiden Sur	name)	
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State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / State Registrar	Certificate of Death	Reg. No.2 0 0 8 0 1 7 0 3
Ą	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year
	/Medi Examir	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	01 19 08 10:15P M
Paris a	*,		7207 N. Alter Street	Baltimore	Baltimore
3.	Funeral Director		5. Social Security Number Continue	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Ob 21 1926 9. Birthplace (State or Foreign Country)
	iryland show 1 at	_	10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits
	the Ma 28a-f s notified	recto	Mb Baltmore D	Saltimore 101. Zip Code	1 ☐ Yes 2 No
	eath with is 23a or must be	Funeral Director	7207 N. Alter Street	21207	USA
9036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ▼ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	i within 72 h jiene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4or 5+) AVA QL N/A	ia. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Mail Hand lev	16b. Kind of Business/Industry United States Dest Office
Maryland 2	should be filed and Mental Hygi marked other umatic event, th	To Be C	17. Father's Name First, Middle, Last) Altred Nenemian Carter		ne (First, Middle, Maiden Surname) J. Bla
	1 and 2 sho Health and em 27 is ma		Many E. Carter/Wife -	7207 N. Alfer Stree	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1		Date 20c. Location - City or Town, State Lo 08 Pikeouille IMD
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licensee **Daughty C. M**	22. Name and Address of Facility Vo 8728 Liberty Road	lughn C. Greene Funeval SVCS Randallstown MD 21133
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a.		Onset and Death
	/Medical Examiner		Due to (or as a consequence	9 of):	unceiz 14 franc
),	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, learner, to make a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence consequence.		
68760,	fficate be g physicia is the bur	edical	d		
P.O. Box	ath cer ttendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3□Ectopic pregnancy 5□ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	quires that the de n signed by the a ald be detached f	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
Vital Records,	sician: The law requires certificate has been si irector, page 2 should b	Completed			24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 I No 1 ☐ Yes 2 I No 1 ☐ Yes 2 I No
Vita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Othor	th (Check only one)
n or	ng Phy fter this neral d	n: To	Thipadori 2 Live	Dutpatient 3 DOA Other. 4 Nursing Hotel Nurs	ome 5 M Residence 6 Other (Specify) 28d. Describe how injury occurred
Division or	I or Attending Physician: The after death. Director: After this certificate ha in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, f building, etc. (Specify)	M 1 ☐ Yes 2 No	28f. Location (Street and Number or Rural Route Number, City or Town, State)
□	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) Medical Examiner: On the basis of examination a gard manner retrieved.	pe, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	Fo the vithin 2 Fo the comple	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)	. , , ,		***	D33759	January 24, 2008
10	4		30. Name and address of person who completed cause of death (item 23a)		
V	Sta Registra	te	31. Date filed (Month, Day, Year) JAN 2 5 2008 32. Registrar's Signature	. D. JJS. Green	C. Dalto, MU XIXVI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 22, 2008 Eileen Marion Croswell 11:00 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore County Timonium If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 09, 1925 Mitchell, S.D. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F 503-22-4199 82 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford County Fallston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2502 Claret Drive 21047 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Lawrence Neises Margaret Spader ၉ 19a. Informant's Name/Relationship (Type. Print) (Daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mrs. Sharon Grimmel-Olszewski 2502 Claret Drive 21047 Fallston, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or conce. 1 Burial 2 □ Cremation 3 ☐Removal from State Highview Mem.Gardens Jan.25,2008 Fallston, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility reaceful Alternatives Funeral&Cremation Ctr., P.A. 2325 York Road Timonium, Maryland Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Coxporascul a. Alheroscleroro disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting is doubt). Due to (or as a consequence of) Examiner death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 Yes 2 No 9 ☐ Unknown The faw requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed' certificate 1□ Yes 2-2 No Division or Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

◆ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this completely filled in by the funeral 27 Manner of Death 28a Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARIO MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JANUARY

32. Rigistrar's Signature

TIMONIUM

MD

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 1618 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Marylan 7. Age (In yrs. Hours Min. 8. Date of Birth Month, Day If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Hours Days Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Des 2 No Director 1011 Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armen Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or iter any injury or other traumatic event the Mariana. 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 □ No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) prrectional 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 3318 Lizzie C. Cephas Briston St etv 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State 1-29-08 wasnile. 4 ☐ Donation 5 ☐ Other (Specify) uneral Service Licens 22. Name and Address of Facility 270 Fred HILT IP: march Filt, it disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat use (F disease ndition resulting in death) use (Final **Physician** /Medical Dua to (or as a consequence of): Examiner ax gronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1□ Yes 2□ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 📉 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy 1□ Yes 2 V No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 □ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) ner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)

27

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0006412

DQ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** E. CAGE 22 anuary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square HospiTAL Center Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 20, 19. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F 74 **Director** 1933 Maryland 214-30-5501 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show miner must be notified at 1 ☐ Yes 2X No Directo Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 Alexis Drive 21085 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. other traumatic event, the Medical Examiner 1 TYes 2 No If Yes. Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ▼No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Director of Operations</u> Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Clyde Wood Henry Carl Cage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traumone. JoAnn Cage / Wife 1404 Alexis Drive, Joppa, MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 1-24-08 Towson, Maryland Signature of Funeral Service License McComas Funeral Home, P.A. 23a. Part1. Intel the disease, or complications that aus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, be art failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RIGHT VENTRICULAR FAILURE Physician /Medical **Examiner** EMPHYSEMA Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the she had the burial-transit Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANTERY 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Pate signed (Month, Day, Year)

funeral director,

After this

within 24 hours after death To the Funeral Director;

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland Hygiene.

"natural",

than

of Health and Mental Hygid Item 27 is marked other

Maryland 21215-0036

Baltimore,

51

31. Date filed (Month, Day, Year) JAN 2 5 2008 Registrar

LiASPEN MO, 9106 PHILADELPHIARD, PSPUTO, NO 21237 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20, 2008 **Physician** January Vnn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numb Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 217-80-1270 Director Usual Residence of Decedent 10c. City Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director MD 10g. Citizen of What Country? 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced VALERI Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+ Child Teacher years 124ears 18 Mother's Name (First, Middle, Maiden Surname) Be ဂ JANIELS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ikesville MDZ1208 Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 Removal from State Baltimure MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Randallston, MD21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) POXEMIA **Physician** /Medical Due to or as a consequence of): Examiner meumon1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine eas The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) led by the a detached f ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be lirector, page 2 s autopsy performed? Yes 2 No Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۴ this within 24 hours after dean... To the Funeral Director: After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 25 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

Black, White, etc.

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

Month

1 Yes 2 No

3:55 P M

State Registrar

Medical

DHMH 17 Rev 1/2001

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mothuar 2 23, 2008 11:55M **Physician** STANLEY F. DABKOWSKI /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/14/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Director 216-16-1676 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits r 28a-f show notified at 1 □Yes 2 □MNo Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be a 8719 LITTLEWOOD ROAD 21234 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) l and 2 should be filed w lealth and Mental Hygier m 27 is marked other th 11TH GRADE LITHOGRAPHER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES DABKOWSKI GENEVIEVE SZYMBORSKA ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a sut: If item 27 is ury or other trains REGINA T. DABKOWSKI/WIFE 8719 LITTLEWOOD RD. BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or permit. Page Department of Important: If any Injury or MOST HOLY REDEEMER 1/29/2008 | BALTIMORE, MD CEMETERY and Address of Facility THE JOHNSON FUNERAL HOME, 21. Signature of Eunoral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASYSTOLE Sequentially list conditions Due to for as a consequence of Examiner ll and leading to infriedrace ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Box 68760. physician pe Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) P.O. ed by the a 9 Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perforn this certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 🗀 Inpatient 2 ER/Outpatient 3 □ DOA P 27. Manner of Death funeral 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No al or Attend s after death. death. the 6 Could not be 3 ☐ Suicide 26e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number

State Registrar

R. SERENA NOLAN. 31. Date filed (Month, Day, Year) JAN 25

M. D. 7601 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON, MARYLAND 21204

D25010

29d. Date signed (Month, Day, Year) MANUARY 24, 2008

State of Maryland / Department of Health and Mental Hygiene Terrificate of Death

State of Maryland / Department of Health and Mental Hygiene Terrificate of Death

Red. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2215 PM DAVIS 0 2008 JOHNNY M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OF MARYLAND NEO: VAL COURS UNIVERSITY BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M 2□F Director 214-54-5916 58 3, 1949 S. Carolina Nov. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland N/ABaltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21217 USA 2148 Mt. Royal Avenue Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: USA 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) , the Mr Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver RC Cola 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Ellis Roy Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2148 Mt. Royal Terrace Baltimore, Maryland Kimmoley Horton/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery $1/25/\frac{67}{67}$ Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chatman-Harris Funeral Home 21. Signature Funeral Service Licensee 22. Name and Address of Facility 5240 Reisterstown Rd Baltimore, Md 21215 Tant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hand failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -ACUC AUDOS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** poxenica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner atom attending physician and for use as the burial-tran EXAMINES Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death Add. Date of delivery 23b. Was decedent pregnant IFICATION Onth 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy 1□ Yes 2□No funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 No 2 Accident MUNITURE HOVSE Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City of Town, State) determined 4 Homicide 2148 Mountain Royal Athome Terrace Detruncies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 21217 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcolini Geere Baltimere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:44/5M FANNIE 7,2008 TANUMORY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1300 SECTURS 405PITAL BALTIMORE 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) Virginia 1 □ M 2 🖾 F 1934 July 1, 218-14-0220 73 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.

• marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 1800 Hollins Street, Apt. 103E 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Black Baltimore, Maryland 21215-0036 Specify: ρ 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public School School Cook 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Bartee Willie Davis ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1815 High Rock Road Cumberland, VA 23040 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is rr any injury or other traum once. James Baker/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ridgeway Baptist 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Buriat 2 ☐ Cremation 3 ☐ Removal from State 1-25-08 Other (Specify) 4 □ ponation Dillwyn, VA Church Cemetery 22. Name and Address of Facility Reid's Funeral Home 21. Sign vure of Fundal Service Licens Dillwyn Virginia PO Box 247, 15317 N. James Madison Hwy, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): minutes Physician /Medical Examiner sabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner hypertension burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical upercholesterolemia the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by tate has been signification 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Physician: The 2 1 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending

within 24 hours after death.

To the Funeral Director: filled in by completely

Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

ne and address of person who completed ourse of death (Item 23a) (Type, Print) Mayo

and manner stated.

m 23a) (Type, Print) Bon Secours Hospital

January 17, 2008 2000 West Baltmore St Baltimore, MD 21223

longlas 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

2008 JAN 25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	5. Sociel Security Number 6. Se 215-22-2043 Usuel Residence of Decedent	7. Age (In yrs. I ☐ M 2 ☐ F 81	last birthday) If Under Months Yrs.	1 Year If Under 24 Hrs Deys Hours Min		h y, Year) 26	9. Birthpla Countr MD	ace (State or Foreig ry)
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within 2 To the comple		and manner stated.	200	License number		20d Date signer	(Month F	av Vegri
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State Registrar	31. Dete filed (Month, Day, Year)	32. Registrer's Signatu	ure					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year rea 152M 0 ~ 2008 /Medical 4a. Facility Name (I) not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2 UVNI If Vinder 24 Hrs. B. Date of Birth (Month, Pay, Year) Social Security Number 6. Sex 1 M 2 F Birthplace (State or Foreign Country) last birthday) **Funeral** Months Days Director 233.94.2591 50 WV Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 28a-f show 10d. Inside City Limits at 1 Yes 2 No be notified Director WV TUCKER **PARSONS** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 206 JAMESON AVE. by Funeral 26287 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Giv**XX** Year or Dates: Baltimore, Maryland 21215-0036 Is marked other than "natural", or aumatic event, the Medic. ■ Exami 1 ☐ Yes 2XXNo Specify Specify. 3 Widowed 4 Divorced MHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER TRANSPORTATION item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ ODFORD GRAY MARCARET PAULINE TAHANEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 CAROLYN SUE GRAY WIFE 206 JAMESON AVE. PARSONS WV 26287 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or ot 1 XX urial 2 □ Cremation 3 XX emoval from State 4 □ Donation 5 □ Other (Speci PARSONS)CITY CENETERY 1.25.2008 PARSONS, WV GRECORY FINK 21. Sign P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HMY S. GLEN BURNIE, MD 21061 M01148 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Enter the diseas , or heart falure. Immediate Cause (Final disease or candition resulting in death) **Physician** terioscler /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as t ate has been signed by the attending or page 2 should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes 2 No Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 No 1 🔲 Inpatient 2 KER/Outpatient 3 DOA this After t 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 X Natural 5 Pending investigation death. 2 Accident 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 125

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State

Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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Certificate of Death

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 01 John P. Garrity /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GOOD SAMARITAN HOSPITAL None Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1X M 2□ F Maryland July 30, 1921 86 Director 213 16 3777 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 21043 4725 Gawain Place Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: White 3altimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Jessup Correctional College (1-4or 5+) Elementary/Secondary (0-12) Facility Warden 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Hauf John Garrity ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13 Donagh Court Timonium, MD 21093 of Health a Richard Mitchell/Step-Son item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Eldersburg, MD 1-29-2008 4 □ Donation 5 □ Other (Specify) Lakeview Mem. Park 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Lipensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1∏ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2/1 No 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 Inpatient Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jabaly

State

Registrar

SABAEVA ELI.
31. Date filed (Month, Day, Year)

4 GOOD SAMARITAN HOSPITAL
32. Begistrar's Signature

1/N 9 5 2000 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #30 Per DVR G875 1/25 Optificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 23 **Physician** JANUARY 2008 5:56A DANIEL DAVID GOTTLIEB /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **BETHESDA** MONTGOMERY SUBURBAN HOSPITAL Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours (Month, Day, Year) 11/08/1927 103-20-4694 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director **ESSEX** WEST ORANGE NJ 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. 24 LATIS CIRCLE 07052 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No KOREA If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) MEAT WHOLESALER s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th Department of Health and Mental Hyginimortant: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATZ HARRY GOTTLIEB BELLA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 24 LATIS CIRCLE, WEST ORANGE, NJ JUDITH KAPLAN GOTTLIEB / WIFE 20b. Place of Disposition (Name of competery, cramstry) or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 Donation 5 Dother (Specify) 01/25/2008 WOODBRIDGE, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Scott 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Nosocomial /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9☐Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Winknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy ormed2 2 No Ostroporosis topenia 25. Was case referred to medical examiner? (26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient Certification: To After this funeral 28b. Time of 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0062167 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road Clinton,MD 20735 Hossein Akhondi

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 5 2008

January 23,200-

			For State	State of Ma	ırylan	-	artmen <i>tificat</i>				-	- /	2002	01	716
			Registrar Decedent's Name (First, Middle, Last)	ot)			imoat	COIL	Jean		. Date of De	Reg. No.		3. Time o	of Death
	Physicia /Medic		George L. Hyman								MAN LINE	ARY	22, Year	ØB 10	:350
	Examin		4a. Facility Name (If not institution, give	street and number)	. Ce	nter	4b. City,	Town, or	Location	of Death	on	4c.	County of Dea	hltimo	ne e
ne.	Funeral Director		5. Social Security Number 6. S 216-14-7958	ex 7. Age	85	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Bir (Month, Da 8-22-1	y, Year)	Co	thplace (State ountry) cyland	or Foreign
-	70		Usual Residence of Decedent			. Town out o	antin n								Na. I inclas
	show	'n	10a. State 10b. County	,		y, Town or Lo								10d. Inside C	2 X No
	the M 28a-f notifie	rect	Maryland Harfor 10e. Street and Number	a		Bel Ai	10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	3a or	iO E	1300 H. Scottsdal	e Drive				21015	5			τ	J.S.A.		
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral Directo	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 X Yes 2 □ N If Yes, Give			Vas Dece f Yes, spe l □ Yes		ispanic Or in, Mexica Specify		ify Yes or No ican, etc.))-	14. Race - Ame Black, Whit		
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	be file	Be	17. Father's Name (First, Middle, Last) George W. Hyman								First, Middle, othlir		111		
2	hould id Mer marke matic	2	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	a Address	(Street a					or Town, State,	Zip Code)	
<u>0</u>	nd 2 s lith an 27 is r r traui		Stephen Hyman (So			1	•				MD 21		, ionii, olalo,	_, p	
n L	es 1 a of Hea f Item r othe		20a. Method of Disposition 1	Romoval from State	20b. P	Place of Dispo emetery, crer	sition (Nar natory or o	ne of other plac	e)	Da	te	20c. Lc	ocation - City or	Town, State	
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000	Departimbor		21. Signature of Juneral Service Licer	nsee									ral Hor		el Ai:
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ر د	hat the d by ti letach		9 ☐ Unknown Part II. Other significant conditions of	ontributing to death bu	it not resi	ulting in the u	nderlying (ause dive	en in Part	1	23e. Did	tobacco i	use contribute t	the cause of	death?
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SIOIS	ding Physician: The fav n. After this certificate has funeral director, page 2	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury	M	28c. Injur Worl	yat k? Yes 2.⊑		3d. Describe	how injui	ry occurred		
	or Attendation death	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined						103 2		If. Location (City or To	Street an wn, State	nd Number or R	ural Route Nu	mber,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical Co		ysician: To the best on niner: On the basis of and manner sta	examina										(s)
	To the within To the comp	Me	29b. Signature and title of certifier	Luste	le:	Mil) ²⁹		e number 1826				te signed (Mon	-	
	.0		30. Name and address of person who	completed cause of de	eath (Item	n 23a) (Type,	Print)								
	10		RICHARD LINTH				OSL	ER I	DRIV	E, T(NOSWC	" Mf	RYLAN	D 2120	34
	Sta	ite	31. Date filed (Month, Day, Year)	32, Registra	ar's Signa	ture	and of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🗍 🗍 🖁 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 01:40 AM 18 IAM JANUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Year If Under 24 Hrs. HOSPITAL 8. Date of Birth (Month, Day, Year) 5-1-1930 Birthplace (State or Foreign Country) If Under **Funeral** Days Min. XXM 2 F s.c. Director 220-26-1849 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1X Yes 2 No 7 is marked other than "natural", or Items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified. Director Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1003 Somerset 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic even. ... Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Post Office Handler 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hamilton ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto, MD 21202 Martha Hamilton - Wife 1003 Somerset Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-22-2008 Balto, MD Greenmount Cem 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee 21202 North Avenue Balto, MD 1101 E. breit 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death A HOURS Immediate Cause (Final disease or condition resulting in death) Physician VOIEMI /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760,arphiDue to (or as a consequence of): physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No page 2 s certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 KER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MEDICAL 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOIFE STREET, BAITIMORE, MARYLAND Tallo 31. Date filed (Month, Day, Year) 32. Red State Registrar

		Please	Type or Prin								egible.		
		For State	State of Ma	aryland /		artment of F		and Men		giene Reg. No.	2008	101	719
三	-	Registrar 1. Decedent's Name (First, Middle, La	ast)			Timeate of	Death		Date of Dea	ath		3. Time of	Death
Physicia /Medic		JUDITH ANN HAR	LAN						Month ANUAR		Year 2008	10:1	5 A M
Examin	4 4	4a. Facility Name (If not institution, give				4b. City, Town, o		f Death			County of Deat		
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with that or 28 be no	Dire	10e. Street and Number	:11 - Dana			10f. Zip Code				•	en of What Co	untry?	
ms 23	Funeral	2840 Pleasantv	12. Was Decedent I	Ever in U.S.	13.	21047 Was Decedent of H If Yes, specity Cub		gin? (Specify	Yes or No-	US ₂	4. Race - Ame		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	(Type. Print)			ing Address (Street	and Numbe	er or Rural Ro	oute Numbe	r, City or			
1 and 2 Health em 27 i		William A. Harlar 20a. Method of Disposition	n / Husband			Pleasant		Road,	Fall		, MD 21 cation - City or		
Pages nent of t int: if ite		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				osition (Name of ematory or other pla alls Frie	1	1_22_0			lston,		Бе
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death certifica attending ph	Physician/Medica	iF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome							2	3d. Date of del		
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has bee	Completed	Inguareans 24a. Was an autopsy							sy	24b. Were autopsy findings available prior to completion of cause of			
iclan: The certificate ha									1□ Yes		death? 1 ☐ Yes	2□ No	
Physician: rthis certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	ent 2 ⊟ER	/Outpatie	ent 3 DOA Oth	or.	of Death (Ci			X Other (Spe	cify) HOSF	'ICE
ng Phys (fter this uneral dii	no.	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 28 y Year)	b. Time o	Wo			Describe h	now injury	occurred		
Attending r death. ector: After by the fune	icati	2 Aocident investigation 3 Suicide 6 Could not to	28e. Place of init	urv - At home	, farm, st	M 1 L	Yes 2 □ I		Location (S	Street and	d Number or Ru	ural Route Nur	nber,
ai or A s after ai Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)					City or Ton	n, State)			
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical (29a. Certifier 1 X Certifying 9 (Check only one) 2 1 Medical Exa	hysician: To the best miner: On the basis of and manner sta	f examination	dge, dea and/or i	th occurred at the tine tine tine tine tine tine tine tin	me, date an opinion, dea	nd place, and ath occurred a	due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To th withir To th	Me	29b. Signature and little by certifier	ps no	25		29c. Licens	se number	inh		29d. Date	e signed (Mont	h, Day, Year)	
12		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type	, Print)							
Sta		DR. EDDIE NAKE 31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	9	ALLEY RD.	TIMO	ONIUM,	MD 21	1093			
Registr		JAN 2 5 200	0		A SAME								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #3, perMD, g875, 1/31/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month P_{M} Bernadette Evelyn /Medical Hicks 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8009 Mollye Road Apt Pikesville Baltimore if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 F Hours Yrs. 59 Director 218-46-6112 DЗ MDUsual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show Idical Examiner must be notified at Directo MD 1 Yes 2 No Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with toment of Health and Mental Hygiene, ament of Health and Mental Hygiene, ant if item 27 is marked other than "natural", or Items 23a or: ury or other traumatic event, the Medical Examiner must be no 8009 Mollye Road Apt c by Funeral 21208 S A
14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Marvland 21215-0036 1 □ Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired)

Patient Services Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Billing Representative 12th GRADE Community Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Evelyn, Thomas James, Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michelle, Thomas-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

| 8009 Mollye Road Apt C Pikesville, MD 21208 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or King Memorial Park 1/26/08 Randallstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H 4300 Wabash Ave, Baltimore, MD 21215 23a. Part1. Enter the disease, or complications that conshock, or heart failure. List only one cause on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** monte /Medical resulting in death) for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine ling physician and Ce as the burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. | been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to peath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? res 227No 2 No 9 01 1□ Yes 25. Was c. se referred medical Be 26. Place of Death Check only one) examiner? Hospital: 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) P 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. To the Hospital or Attence within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and th (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

istrar's Signature

5 2008

401 W. DELVEDENE AVE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland	/ Departmer	nt of Health a	nd Mental Hyg	giene	01720
		1	Stata Registrar		Certificat	e of Death		Reg. No. UUO	01/20
	Physicia	an	1. Decedent's Name (First, Middle, Last)	0 0	Tr	NES	2. Date of Dea Month	Day Year	3. Time of Death
	/Medic Examin	_	4a, Facility Name (If not institution, give s	treet and number)	4b. City	Town, or Location of	f Death	4c. County of Dea	h,
	LXaiiiii	C1	Bon Secours	tospital		, .	nore	N/	A
	Funeral		5. Social Security Number 6. Sex 1	7. Age (In yrs. las.	t birthday) If Under Months	r 1 Year If Under 2 Days Hours	Min. 8. Date of Birth (Month, Day	h 9. Bin 7. 1957 Co	thplace (State or Foreign buntry)
	Director	L	Usual Residence of Decedent					71011	-/-
	arylan ehow	_	10a. State 10b. County	10c. City, 1	Town or Location	Battin	And .		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow Innest be notified at	by Funeral Director	Mayland M. 10e. Street and Number	71	10f. Zi	Code	10	10g. Citizen of What Co	ountry?
	th with	al Di	1117 Appleton 5	升:		212	.17	US	4
	tems:	uner		Was Decedent Ever in U.S. Armed Forces?	13. Was Dece If Yes, spe	dent of Hispanic Origodity Cuban Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Ame Black, Whit	
336	hours atter tural', or Ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	ack
5-0036	72 hou	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usu (Give kind of w	ial Occupation ork done during most use retired)	of working	16b. Kind of Business	/Industry
2121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT E	Fice Aid	le	Schools	City Public
	e filed within al Hygiene. I other then '	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name (First, Middle,		
Maryland	2 should be and Mental is marked (aumatic ev	To E	Bernard Jones				otha Jones		Zin Corto) 21213
Mar	s 1 and 2 should be filed within 72 hours atter death with the Marylan I Health and Mental Hyglene. Item 27 is marked other then *natural', or items 23a or 28a-f ehow other traumatic event, I'm Medical Evariater must be notified at		19a. Informant's Name/Relationship (Type Anthony Scott	oe, Print)		s (Street and Numbe	r or Rural Route Numbe	Himore M	ander de
ē,	s 1 an if Heal item 2 other	1	20a. Method of Disposition	com	ce of Disposition (Na netery, crematory or	me of	Date	20c. Location - City or	Town, State
imo	permit. Page Department o mportent: If any Injury or ance.		1 Description 2 □ Cremation 3 □ Rolling 1 □ Donation 5 □ Other (Specify)	emoval from State	Carmel	Cemetery	1/25/08	Baltimore	Maryland
Baltimore	permit. Pa Departmen Importent: any Injury		21. Signature of Funeral/Service License	Parken	22. Name a	nd Address of acility	tarker Fry	rend Home	larward
	40200	2	23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	Do not enter the mo	de of dying, such as	cardiac or respiratory ar	411	A proximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition			ARTE		EASE	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequen					
		ē	Sequentially list conditions, if any, leading to introducte	Due to (or as a consequen		-IVER	D 156	-ASE	
A	and I-transit	Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events	SEIZ	RES				
760,			resulting in death) Last	Due to (or as a consequent	·	ma n	SUTR17	100	
687	0 % 0	edicai	_ d	_SEVER	- C	T INTLIN	VUCKII	7000	
Box (h certiticat ending phy use as th	In/M	23b. was decedent pregnant	3c. If yes, outcome of pregnance 1□ Live birth 2 □ Fetal de		pregnancy		23d. Date of de Month	livery Day Year
	0 0	Completed by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of deat				Mortin	Day
, P.O.	requires that the leen signed by th hould be detache	y Ph	Part II. Other significant conditions con	tributing to death but not resulti	ing in the underlying	cause given in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Vital Records,	w requires that been signed t should be det	ed b	PNGU	monia			10	Yes 2 No 3□P	robably 4 DUnknown
eco	law as b	nplet	HEPAT	ic Ence	PHAL	OPATH	24a. Was	an 24b. Were a prior to death?	utopsy findings available completion of cause of
a B	. 40 -7-		25 144			00 Pi	1 Yes	2 No 15 YB	s 2 No
<u>K</u>		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Mpatient 2 ☐ EF	P/Outpatient 3□ D	Other	of Death (Check only oursing Home 5 Resident		ecify)
n o	ng Phys fter this ineral di	ino	27. Manner of Seath 1 Statural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?		how injury occurred	
Division of	Attending ir death. ector: After by the tune	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	M e. farm. street. facto	1 ☐ Yes 2 ☐	28f. Location (Street and Number or F	Rural Route Number,
ρį	s after of Directory	Certification:	4 Homicide determined	building, etc. (Specify)	,		City or Tox	wn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely tilled in by the tuneral	edicai ((Check only 2 Madical Examin	sician: To the best of my knowledger: On the basis of examination	edge, death occurre in and/or investigation	d at the time, date an n, in my opinion, dea	d place, and due to the th occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	o the	Med	one) 29b. Signature and title of certifier	and manner stated.	2	c. License number		29d. Date signed (Mon	th, Day, Year)
	r> = 0) Edwards	Hogen		D414	230	01-2	2-08
	A		30. Name and address of person who co	mpleted cause of death (Item 2	(Type, Print)		LF7	SP RA	2-08 LTIMBRE
	Sta	to	31. Date filed (Month, Day, Year)	3. Registrar's Signatu		UNSECE	rups the	-JI - 10H	-11110RG
	Sta Regist		JAN 2 5 200	8 person 15	A MONEY				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Emma Jetter 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day January 14, 2008 2028 hrs Medical Examiner Emma Jetter 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** N/A Maryland General Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 3 CourMaryland Days Hours Min Director 84 June 12,192 215-82-0645 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore N/A1 X Yes 2 No 23a or 28a-f show notified at once. Maryland hours after death with the Maryland rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 Royal Terrace 2148 Mt. Ö Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 2 1 X Never Married 2 X No Yes Specify: Black Yes 2 X No specify: Divorced If Yes, Give Year Widowed \$ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 rent of Ilealth and Mental Hygiene. Glen L. Martin Medical MD 21215-0036 marked other than Defense Worker 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, the Emma Valentine Be Morgan Jetter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2309 Eutaw Place Baltimore, Maryland 21217 19a. Informant's Name/Relationship (Type, Print) item 27 is Charles Jeter/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) or other 1 X Burial 2 Cremation 3 Removal from State Lansdowne, Maryland zion Cemetery 1/25/08 partment o Mt. Other Specify Donation 5 22. Name and Address of Facility 22. Name and Address of Facility Chatman 5240 Reisterstown Rd e of Funcial Service 21215 Approximate Interval he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and only one cause on each line /Medical Death Smoke Inhalation Immediate Cause (Final disease ⊊xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that Initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Ling physician and use as the buri-Physician/Medical AMENDED UNPENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of Other (Specify) Jo Yes 2 ✓ No 9 Unknown Unknown as been signed by t should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 V Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed^a death? page Yes 2 V No 2 Yes the Hospitat or Attending Physician: The in 24 hours after death. The Funeral Director: After this certifical pletely filled in by the funeral director, pa 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: Other Other: Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes 27. Manner of Death 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jan 14, 2008 Victim of housefire 0000 hrs Natural Yes 2 V No Pendina 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2148 Mt. Royal Terrace, Baltimore, Md. (Specify) Single Family Home Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal To the ! 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signati) e and title of certifie 29c. License number January 16, 2008 O.C.M.E. 30. Name and address of person who care and ed cause of death (Item 23a) 2 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 January 23, Mab1e S. Jones 5:35 PM/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, June 27, Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕅 F 87 Yrs. Director 254-22-3681 1920 Georgia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1X Yes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Dunton Lane 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No 2 Specify 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be realth and Mental n and Mental Hobson Hardeman ဂ Eva May 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oartment of Health ar sortant: If Item 27 Is Injury or other trau 941 Galahad Circle, Macon, GA 31220 Sonja Maynard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or 4 ☐ Dopation 5 Other (Specify) Macon Mem. Park 1-30-08 Macon, GA 21. Sign vure of Funeral Service Licansee 22. Name and Address of Facility Bentley & Sons Funeral Home 2714 Monpelier Ave., Macon, GA 31204 ennys muca 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner ACMAL VICER Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate | 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Certification: To 1 ☐ Yes 2 No 1 Mpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Records, P.O. Box 68760. Division or Vital

npletely

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINE CENTEL WALDER, Eld.

WISOTILL 12070

31. Date filed (Month, Day, Year) egistrar's Signature **JAN 25** 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 8 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** January 16, 2008 2:09 PM <u>Lisa Ann Jones</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 4, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 28 F Yrs. 1965 Director Maryland 217-88-6856 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 XYes 2 No Directo Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 373 South Drive 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-003 δ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Specialist Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event pose. Be Robert Eugene Green Elizabeth (nmn) Haffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Pytel / Sister 956 Creek Park Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 1-22-08 Towson, Maryland 21. Signature of Funeral Se McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faillers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To this After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: , 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[I] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 10 Brian G. La Roccom Havre South 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN THE MEZI, Per H. 875, 1/2/08, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month

Physician /Medical **Examiner**

Funeral Director

filed withIn 72 hours after death with the Maryland 7 ie marked other than "netural", or Itams 23a or 28a-f show treumatic event. The Medical Examinar must be notified at Hygiene is 1 and 2 should be fit of Health and Mental H item 27 is marked oth other item permit Pages 1
Deparment of He
Importent: If iten
any in ury or oth

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

Physician /Medical **Examiner**

> sician and burial-transit use as the ò detached s been signed be should be deta page certificate director.

The law requires that the death certificate be executed or Attending Physicien: completely filled in by the funeral After death. Director within 24 hours after To the Funerel Dire Fo the Hospitei

1. Decedent's Name (First, Middle, Last) Day Year 14:35 2008 JaNuary Beatrice Kittrell 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 4-23-1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F Yrs N.C. 88 577-28-4047 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tayes 2 □ No Director MD N/A Baltimore 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21206 5525 Silverbell Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Office 12th grade Bank N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Corneluis Kittrell Martha Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 Silverbell Road Balto, MD 21206 Frank Rogers -Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 1-14-2008 Randallstown, 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 Lynette Jones M00727 per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aspiration Immediate Cause (Final disease or condition resulting in death) Respiratory Failure

ras a consequence of):

Metabolic Acidosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death' 2 🗷 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00058570 Tenance 30. Name and address of person who somplyned cause of death (Item 23a) (Type, Print)
Terrance L. Balker MD 600 & Sanar, fan Hospital Baltinore 21236

State Registrar

31. Date filed (Month, Day, Year)

JAN 25 2008 32 Registrar's Signature



Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

istrar's Signature

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enr	neth Michael		nham, Jr. Si I-For State Registrar	tate of Marylan		rtment tificate				Reg. No	20		72
Med	Physicia lical Exami		1. Decedent's Name (First, Midd Kenneth Mic		am T	r	-		2. Date of D Month January		Year	3. Time of Death	ר
	ncai Exami		4a. Facility Name (if not institution			L .	4b. City,	Town, or Location of			c. County of Dea	ath	
			1164 Cedar Avenue				Sha	dy Side			Anne Arunde	el	
	Funeral Director		5. Social Security Number 2 1 6 – 1 9 – 4 5 4 6	6. Sex 7	. Age (In yrs. Ia) If Un Mon		14:-	Birth(MM 1 / 1 9	Fore	Birthplace (State or eign Country) MD	
	, h		Usual Residence of Decedent		Lio. Oh.	Town or Lo						10d. Inside City	Limite
	id how any Ee.	_	MD 10b. County Ann	e Arundel		Shady		de				1 Yes 2	
	Maryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Z	ip Code		10g. Ci	tizen of What Co	ountry?	
	ith the Maryland 23a or 28a-f sho notified at once.		1164 Cedar	Avenue				20764			USA		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Deced			If Yes, spec	cify Cuban, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Am White, etc		ζ,
	after	by F		ivorced If Yes, Give Year or Dates:				2 X No specify:		Trai	Specify:	White	_
	hours 'natu	fed	15. Decedent's Education (Spe Elementary/Secondary (0-12)			16a. Dece	g most of w	al Occupation (Give orking life. DO NOT	use retired)	160.	Kind of Busines	ss/industry	
	036 vithin 72 ene. rr than	Completed	12	0	0.0.7	Cons	struc	ction Wo		1	onstru	ction	
	21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle		r				r's Name (First, Middl			nhv	
	212 uld be Menta mark	Kenneth M. Lanham, Sr. Denise E. Stuart Mu P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow								City or Town, St	ate, Zip Code)		
	MD 2 sho alth and in 27 is aumatic		Denise E. Stua:	rt / Mother					, Shady Si				
	re, l		20a. Method of Disposition 1 Burial 2 X Crematic	on 3 Domovol from		Place of Dis	position (No	ame of cemetery,	Date	20c	. Location - City	or Town, State	
	Pages nent of ant: I		4 Donation 5 Other S		Ba	ıyview		_	1/21/200			•	
	Baltimore, bermit. Pages I ar Department of Hee Important: If iter	1	21. Signature of Funeral Service	e Licensee					y Hubbard				
	Physician		23a. Part I. Enter the disease, o	or complications that cau	sed the death				avenue, Ba			Approximate I	
p	/Medical		failure. List only one cause	se on each line.								Between Ons Death	
	xaminer		Immediate Cause (Final diseas or condition resulting in death)		onsequence o	of):							
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	24	xamine	cause. Enter Underlying Cause (Disease or injury it at initiated	Due to (ee ee e	onsequence o	·f)·							
	nd Age	ш	events resulting in death) Last	d.	onsequence e								
	ox 68760, anth certificate be executed attending physician and for use as the burial - trans	Physician/Medical	UNPENDED	AMENDED							-		
	760, icate b	/Me	IF FEMALE: 23b. Was decedent pregnant in	AL	itcome of preg	nancy				2	3d. Date of deliv		
	certification ce	cian	past 12 months?	I LIVE BII	th nt at time of de	2 eath 5	Fetal deat		ic pregnancy		Month	Day Ye	ear
	Box 68760 e death certificate b the attending physi ed for use as the bu	ysi	1 Yes 2 No 9 Ur		vn	J	Other (or	Cony		1			
	Division of Vital Records, P.O. Box 68760, tal or attending Physician: The law requires that the death certificate be executed as therefore. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - trans		Part II. Other significant cond	litions contributing to	death but not r	esulting in the	ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of d 1 Yes 2 ✓ No 3 Probably 4 U						
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	cords, law requir	Completed by				-			p	utopsy erformed	prior death	to completion of car n?	use of
	tal Recian: The		05.10					26 Place of Dogth		es 2 🗸	No 1	Yes 2	No
	Vital Reconstitution of the service	Be	25. Was case referred to medic examiner?	Manadala .	patient 2	ER/Outpat	26.Place of Death (Check only one) ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 ✔ Other: Scene						
	Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	n: To	1 Yes 2 No 27. Manner of Death	28a Date o	f Injury	28b. Time	of Injury	28c. Injury at Wor			njury occurred		
	ion trendin eath. tor: A the fu	ertification:		nding restigation FOUND: Jan 17, 2		FOUND: 0000 hrs		1 Yes 2 ▼	No				
	Division tal or Attenders after death an Director: led in by the	tific	3 Suicide 6 Cou	uld not be 28e. Place	of Injury - At h		street, facto	ory, office building, e	or Tow	n. State)		Rural Route Numb	er, City
		ъ.	4 Homicide det	termined (Specify)	Single Far	níly			11164 Ceda	ar Avent	ue, Shady Side	е, мо	

Div
To the Hospital or
within 24 hours after
To the Functal Di
completely filled in

Suicide

4 Homicide

29a. Certifier (Check only one) 2 V

29b. Signature and Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number O.C.M.E.

State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar

ORIGINAL

29d. Date signed (Month, Day, Year)

January 18, 2008

Division or Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Medical 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D 3129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21206 6701 N Charles St Sute 4202 1010152 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State IAN 2 5 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Approximate Interval Between Onset and 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, City completely filled in by or Town, State)
1813 Poplar Grove St. BAltimore, MD within 24 hours at To the Funcral E Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 24, 2008 O.C.M.E. Donna My montimo 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra OCME ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #2 Per DVR G875 1/26/08 Hertificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 3. Time of Death Month **Physician** ANUCUT /Medical 4a. Facility Name (If not institution, give street and number) 4b Sity, Jown, or Location of Death County of Death Examiner TIMOK 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 2□ F Months Days Hours Min 114/ 55 218-60-4194 Director MARI 1953 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show r 28a-f show notified at 1√ Yes 2 No MD **Funeral Director** ALTIMORE with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i 2121 ALHOUN U.S.A. 309 death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ⊠ No Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) HEALTH CARE NURSING Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle Last) Be (rith and Mental h ANNIE Blackmon MANNING ပ္ MAE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA LANE APTF Glen Burnie MD 21061 lichael BoTELER- Friend Department of Health Important: If Item 27 any injury or other troone. 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 1-28-08 BAlto. MD 4 □ Donation 5 □ Other (Specify) MeTro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael Ziglier Fun 3512 Fre Derick Aue, hae BA 1+0, MD, 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 cate has been signated by page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 N No certificate Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient ပ္ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 🗌 Yes 2 ∏ No 2 Accident completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and mariner stated. 29b/Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 2

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Collin M. Mazyck

08-00499

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	State of Maryland / Department 1- For State Certificate	of Health and Mental H of Death	ygiene Reg. No. 200	8 0173							
 Physician 	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year										
ledical Examine →	Tollin M. Mazyck 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
	Johns Hopkins Hospital	Baltimore									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	Forei	thplace (State or gn puntry)							
Director	Usual Residence of Decedent	Yrs.	4-16-1983	MD							
any	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits							
daryland 28a-f show any 1 at once.	MD N/A Baltimo		1	1 X Yes 2 No							
th the Maryland 23a or 28a-f sho notified at once.	10e. Street and Number	10f. Zip Code 21218	10g. Citizen of What Cou	intry?							
with the s 23a o		Was Decedent of Hispanic Origin? (S	pecify Yes or No- 14. Race - Ame	rican Indian, Black,							
r death with or items 23 must be no	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto									
s after ral", o	3 Widowed 4 Divorced in res, Give real or Dates:	Yes 2 X No specify: dent's Usual Occupation (Give kind of	Specify: B1	/Industry							
2 hour "natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use ret		N/A							
within 72 hour giene. her than "natu Medical Exan	10th grade N/A										
ry 2 ₹ 2 € (γ	Tr. Famer's Name (First, Middle, Edst)		e (First, Middle, Maiden Surname) Marie Cooper								
2121 ould be fi d Mental I s marked ic event,			Rural Route Number, City or Town, Stat	e, Zip Code)							
MD id 2 sho ilth and in 27 is	Willie Mazyck - Father 15		reet Balto, MD Date 20c. Location - City o	21218							
or Heal		sposition (Name of cemetery, or other place)									
Baltimore, permit. Pages I at Department of Her Important. If ite Injury or other tr	4 Donation 5 Other Specify: King M	2 Name and Address of Facility	24-2008 Randall								
Balt permit. Depart Import injury	Brand or Mellin	Ma 1101 E. Norti	arch F/H East h Avenue Balto	21202 , MD							
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and							
/Medical vaminer	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death							
.*	Sequentially list conditions, b										
	if any, leading to immediate Due to (or as a consequence of):			i							
Parisit led	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	d. UNPENDED AMENDED										
60, ate be e hysicia e buria	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ry							
687 certifica ading p	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy Month	Day Year							
Box 6876: c. death certificate the attending phy ed for use as the l	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in	Other (Specify)									
b, P.O. I	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro								
S, P			1 24a, Was an 1 24b, Were a	autopsy findings available							
cords law requi has been 2 should			performed? death?								
Vital Recystian: The his certificate director, page		26.Place of Death (Check	1 Yes 2 No 1 V	Yes 2 No							
Division of Vital Records, tat or Attending Physician: The law requirers after death. al Director: After this certificate has been a Director, After this Certificate bas been sen by the funeral director, page 2 should be the funeral director.	by 25. Was case referred to medical examiner? O 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	tient 3 DOA Other Nurs	ing Home 5 Residence 6 Oth	er:							
ding Phy. After tl	27. Manner of Death 28a. Date of Injury 28b. Time (Month Day Year) 1 Natural 5 Pandias 1 106 hr		28d. Describe how injury occurred Subject shot								
Sior Attend r death ector: by the	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm,	1 103 2 4 110	28f. Location (Street and Number or F	Rural Route Number, City							
Division pital or At ours after dieral Direct filled in by	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 2 Acmiddle (Specify) Alley (Month Day Sear) 1106 hr. 28e. Place of Injury - At home, farm, (Specify) Alley		or Town, State) 2700 Block of Tivoly Avenue, Bal	timore, MD							
6 = 5 1 1/98 Centiler. I =											
To the Hos within 24 h To the Fur completely	(Check only 1 Certifying Physician: To the best of my knowledge, death of one) 2 Medical Examiner: On the basis of examination and/or investance and manner stated.	29c. License number	29d. Date signed (A								
	E PRED. SIGNATURE OF CHILDREN	O.C.M.E.	January 18, 20								
	30. Name and address of person who completed cause of death (Item 23a)										
3	Laron Locke MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21	201								
Stat Registra		sale									
	JAN M V PT TO THE PARTY OF THE										

OCME

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UNK UNK State of Maryland / Department of Health and Mental Hygiene	0 0172										
1- For State Certificate of Death Reg. No. 200	8 01/3										
Physician/ 1 Decedent's Name (First, Middle,Last) Medical Examiner 1 Decedent's Name (First, Middle,Last) Annuary 17, 2008 2 Date of Death Month Day Year January 17, 2008	3. Time of Death										
Tsaiah McKeiver January 17, 2008 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	2.001.10										
Johns Hopkins Bayview Medical Center Baltimore											
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Bir											
Months Days Hours Min. O 7 0 7 0 0 0 Foreign	n untry) MD										
Usual Residence of Decedent											
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits										
च है था । MD N/A Baltimore	1 X Yes 2 No										
10g. Citizen of What Cour	try?										
MD N/A Baltimore MD N/A Baltimore 106. Street and Number 3520 Cliftmont Avenue 21213 U S A 14. Figure 1.0 Street and Number 106. Street and Number 107. Zip Code 108. Street and Number 108. Street and											
11. Marital Status 1 X Never Married 1 Yes 2 X No 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amer White, etc.	can Indian, Black,										
The vertical land of the verti											
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/	ack										
during most of working life. DO NOT use retired)											
18. Becedent's Source Completes of Working life. DO NOT use retired of working life. DO NOT use retired of the complete of the	N/A										
18. Mother's Name (First, Middle, Last)											
Property of the state of the st											
Description of the purpose of the pu											
Rhonda Lewis - Mother 3520 Cliftmont Avenue Balto, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or	21213 Town, State										
250. Wellist of Disposition (Value of Disposition) 1 X Burial 2 Cremation 3 Removal from State crematory or other place)											
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Carmel Cemetery 1-26-08 Baltimory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East	e, MD										
21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East	21202										
Physician 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval										
failure. List only one cause on each line.	Between Onset and Death										
Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of Head and Right Shoulder Due to (or as a consequence of):											
Sequentially list conditions, b											
if any, leading to immediate Due to (or as a consequence of):	Į:										
(Disease or injury that initiated overthe resulting in death). Last Due to (or as a consequence of):											
(9 8 2 Ⅲ											
d. Comparison of the part of the past 12 months? 1											
The part of the past 12 months? Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 23d. Date of deliver Month											
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	Day Year										
Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	the cause of death?										
The part of the pa	ably 4 Unknown										
Participant of the proof of th	topsy findings available completion of cause of										
Deformed? death? 1 ✓ Yes 2 No											
The state of Death (Check only one) 25. Was case referred to medical examiner? 1 V Yes 2 No 1 V Y 26. Place of Death (Check only one)											
25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other	r:										
The state of the s											
Subject shot Subject shot Subje											
286. Place of Injury - At home, farm, street, factory, office building, etc. 286. Location (Street and Number or R or Town, State)	iral Route Number, City										
☐ 💆 🚆 🖥 🗸 Homicide determined (Specify) Alley rear of 3508 Cliftmont Avenue, Ba											
Trear of 3508 Cliftmont Avenue, Ba	ad										
age and O 29a Certifier	e cause(s)										
Homicide 29a. Certifier 1 Cheek only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed. (Manual Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). After the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and place and place and place and place a	ne cause(s)										
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to to and manner stated. 29b. Signature and title of certifier 29d. Date signed (Me	ne cause(s) onth, Day, Year)										
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the same manner stated. 29b. Signature and title of certifier 29d. Date signed (Months) O.C.M.E. January 18, 200	ne cause(s) onth, Day, Year)										
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to to and manner stated. 29b. Signature and title of certifier 29d. Date signed (Modern States) 30. Name/and address of person who completed cause of death (Item 23a)	ne cause(s) onth, Day, Year)										
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the same manner stated. 29b. Signature and title of certifier 29d. Date signed (Months) O.C.M.E. January 18, 200	ne cause(s) onth, Day, Year)										

08-00518

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eugene Marks	State of Maryland / Department of Health and Mental Hygic - For State Certificate of Death	Reg. No. OOO OITO								
Physician/	1. Bosodonico Patrillo (1 mot, Middio, Edity)	ate of Death								
Medical Examiner	4a. Facility Name (if not institution, give street and number) Fugene Anthony Marks 4b. City, Town, or Location of Death	anuary 18, 2008 1128 hrs 4c. County of Death								
	Washington County Hospital Hagerstown	Washington								
Funeral Director	Months Days Hours Min.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M.D.								
	Usual Residence of Decedent	1-16-1966 Country) MD								
м апу	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No								
Maryland 28a-f show 1 at once.	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?								
with the Maryland ms 23a or 28a-f sh	309 N. Robinson Street 21224	U S A								
Baltimore, MD 21215-0036 pennit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Rical Yes, specify Cuban, Puerto	y Yes or No- 14. Race - American Indian, Black, on, etc.) White, etc.								
ter dear, or it	1 Yes 2 No No Specify:	Specify: Black								
iours af	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	done 16b. Kind of Business/Industry								
36 iin 72 h ihan "n dical E	Elementary/Secondary (0-12) College (1-4 or 5+) 9th grade N/A Maintenance	Private Company								
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Comple	17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir	st, Middle, Maiden Surname)								
121 d be fill fental F narked event,	Eugene Felder Delilah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura									
MD 21 nd 2 should alth and Me m 27 is man raumatic ev		eet Balto, MD 21205								
re, h I and F Healtl Fitem er trau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	ate 20c. Location - City or Town, State								
Baltimore, permit. Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: Mt Carmel Cem 1-26	-08 Balto, MD								
Balt permit Depart Impor injury	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Marc 1101 E. North	h F/H East Avenue Balto,MD 21202								
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restailure. List only one cause on each line.	spiratory arrest, shock, or heart Approximate Interval Between Onset and								
M. cical vaminer	Immediate Cause (Final disease a. Seizure disorder	Death								
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,									
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
ted of the misit	events resulting in death) Last Due to (or as a consequence of):									
execu an and all - tra	X UNPENDED AMENDED #23, PII, 27, perME, g876, 2/28/08 TT									
Box 68760, to death certificate be the attending physicited for use as the burind for use as the burint burinsician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery								
Sox 6876 Jeath certificate e attending phy for use as the l	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Month Day Year								
the death by the att iched for Physical	Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
ires that the signed by a signed by a lbe detach.	Atherosclerotic cardiovascular disease	1 Yes 2 No 3 Probably 4 Vunknown								
Records, The law requires fricate has been sig		24a. Was an 24b. Were autopsy findings available prior to completion of cause of								
tal Records cian: The law requi certificate has been ector, page 2 should Be Complete		performed? 1 Yes 2 No 1 Yes 2 No								
Vital Recysician: The Institute Institute director, page	25. Was case referred to medical examiner? 4 Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other, 4 Nursing H									
1 of Vildang Physic L. After this funeral dir.	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28	d. Describe how injury occurred								
ion (tendin eath. A the fur	Accident Investigation									
Division of Vital Records, P.O. pital or Attending Physician: The law requires that thours after death. Inval Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach Certification: To Be Completed by P	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rou or Town, State)									
id no alia	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du-	e to the cause(s) and manner as stated.								
Division o Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e time, date and place, and due to the cause(s)								
[] E	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 19, 2008								
8	30. Name and address of person who completed cause of death (Item 23a)	54.754.7								
P	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registra										
Registra	OCME									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 23a per dr., g875, 01 625 408 allabor Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Lorraine McGuire SUSANI 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore le dica ercy timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July19,1962 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Year **Funeral** Days Hours 1 □ M 2 🔀 F 220-72-7519 45 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD Baltimore Essex 1 ☐ Yes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or ner must be 101 Woodsmans Court 21221 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: þ 3 ☐ Widowed 4 ☐ Divorced natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) the Legal Secretary Saul Ewing LLP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Frank E. Carrigan Rita Tucciarella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Woodsmans Court Baltimore MD 21221 Brian F. McGuire /husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 1/15/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Probable, Heart Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Onknown Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 1∐ Yes 2 1 No To the Hospital or Attending Physician: 25. Was case referred to medica examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗌 Natural Injury nours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Gould not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a forther than the formpletely filled is 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0006002

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

10,0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:35 A^M Jan 15 2008 Helen A. Mihaly /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)
March 14, 1917 New York 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Yrs. 90 208 09 8801 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 20735 United States <u>9721 Hale Drive</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give XX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2【XXIVo Baltimore, Maryland 21215-0036 Specify: Specify: White 3∏Widowed 4☐Divorced ρ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8th <u>Care Giver</u> <u>Va Hospital</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Wozniak Antonia Kimosa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s' of Health ar if Item 27 is or other tr 9721 Hale Drive, Clinton, MD Jane Scoleri (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 22. 20c. Location - City or Town, State 20a. Method of Disposition perrit. Pages 1
Depirtment of H
Important: If Itel
any Injury or ott 1 NBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Braddock Catholic Cemetery Pittsburgh, Pa 21. Signature of Fureral Segring Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria FerryRoad, Clinton, MD 20735 Approximate Interval Between Onset and Death ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** our hy thimle 2 days Cardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Dixot Dacxm Sequentially list conditions, Due to ur as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive

Due to (or as a consequence of): ailure heasit attending physician and for use as the burial-tran 68760 Anemia Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death been signed by the should be detached 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, þ 1 Yes 2 No 3 Probably 4 ☐ Unknown phollahon Completed Amal 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Aherma performe 1□ Yes 2☑No or Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

State Registrar

VALIV 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 25 2008

SHRI

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifier

Kennen



7503

29c. License number

063183

SURRATTS

ROAD

29d. Date signed (Month, Day, Year)

CLINION

MD-2073

Ø

State 31. Date filed (Month, Day, Year) 2008

Patricia Aronica-Pollak MD.

32. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 16, 2008

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** GAIL REGINA MILLER 22, 2008 JAN. 11:38A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL HOSPICE DOVE HOUSE CARROLL If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 56 Director 216-62-2899 8/28/1951 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f sh notified a 1 Mayes 2 □ No Director MD CARROLL NEW WINDSOR 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ", or items 23a or 20 caminer must be no 301 CHURCH ST. 21776 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural"; or ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE n other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM WAGNER MILLER ELIZABETH M. HUBBARD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM W. MILLER -FATHER 301 CHURCH ST., NEW WINDSOR, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) ALL COUNTY CREMATION 1/23/08 SYKESVILLE, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME, 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed y physician and as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performe 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify)HOSPICE 1 ☐ Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295

Stener

32. Reastrar's Signature

MIRC

31. Date filed (Month, Day, Year)

00059943

22,2008

08-00433 James Patrick Madore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008

Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year			- For State	,	Certifi	cate of	Death		, ,	Reg	j. No.				
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29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. 30. Name and address of person who complet to cause of dath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Rejistrar's Signature	Sicolar dea	<u>8</u>		290 Place of Injur		_		e building, et	tc. 28	f. Location (S	Street and Number o	r Rural Route Number, City			
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			31. Date filed (Month, Day, Year)	2008 32. Redistrar's	Signature	TO THE STREET									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day, ___ YRAUNALY **2008** 219: 214FM **Physician** John Edward Norman /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 17, 1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country Days 1 M 2 □ F 219-18-5209 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐Yes 2 XNo Carroll Sykesville MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 407 Piney Run Ct. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 M Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: White WWII 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Refrigeration Refrigeration Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Michael Edward Norman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 Piney Run Ct., Sykesville, MD 21784 Mrs. Norma J. Norman (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State Sykesville, MD Lake View Mem. Park 1/28/2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 L. Hought NOOX64 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RUPTURED ABDOMINAL AORTIC ANEURYSM /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 1 Yes 2 No 1 🖪 Inpatient 3□ DOA 10 this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury Certification: neral Director; After filled in by the funer (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

5

31. Date filed (Month, Day, Year) 2008

TIMOTHY LOW.

29b. Signature and title of certifig



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24034

29d. Date signed (Nonth, Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Nella Orlando 4:17 AM M 18, 2008 January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) #259 Bowie Prince George's 14997 Health Center Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Win. | Feb 8, 1922 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Italy 1□ M 2 🕏 F 85 040-28-3734 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must have any longe. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√2 Yes 2 No Director Prince George's Bowie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20716 14997 Health Center Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: 9 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Caterer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria (Unknown) Santo Pinzuti 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5141 Solomons Island Rd. Huntingtown, MD 20639 Anthony Orlando 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial, 2 □ Cremation 3 □ Removal from State St. Mary's Cemetery | 1-28-08 Greenwich, CT 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Castiglione Funeral Home 134 Hamilton Avenue Greenwich, CT 06830 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Chronic Obstructive Pulmonary Disease **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Pulmonary Fibrosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atrial Fibrillation autopsy performed? Yes 2X No 1 ☐ Yes 2 No certificate 1□ Yes Hypertension Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 Tyes 2**X** No Certification: To After this 28b. Time of 28d. Describe how injury occurred filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58289 1-18-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4175 N. Hanson Ct. Bowie, MD 20716 J. Hoeck, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 25 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Pryor ollie Tanyary 1843 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bultimore Randallstown Hospita NorthWest If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 7 Yrs. 214-72-8509 49 Director May 8, 1958 Japan Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2930 Edmondson Avenue 21229 USA 238 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 232XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 ie marked other then College (1-4or 5+) Elementary/Secondary (0-12) 12 healthcare hospita1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ennis Pryor Sadie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernie Davis / Uncle 6207 Winner Avenue; Baltimore, Maryland 21215 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H important: if Ite eny injury or ott once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 01/24/2008 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes this certificete hes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 💢 1 Tyes : After this certifice e funeral director, f Be 25. Was case referred to medical 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No the Director: 3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Cartifying Physician: To Madical Examinar On the 29a. Certifier the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manifer stated. (Check only

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. within 24 hours e To the Funerel I completely filled ě

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certified

30. Name and address of pers

31. Date filed (Mor

DHMH 17 Rev 1/2001

ORIGINAL

death (Item 23s) (Type, Prin

Registrar's Signature

29c. License number D0034526

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 7:30 P M 23, 2008 January Pate1 Samir K. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Gaithersburg 142 Mission Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 X M 2 □ F Maryland July 12, 1967 Director 40 219-74-7323 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County show "natural", or Items 23a or 28a-f shov sd⊫al Examiner must be notified at 1X Yes 2 No Directo Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 142 Mission Drive United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: þ Asian-Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than Flementary/Secondary (0-12) n/a Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Divya S. Patel Kaushik C. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gaithersburg, Maryland 20878 142 Mission Drive Kaushik C. Patel/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 1/26/2008 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) Signature of Funeral Service Licep 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 4 nomas 1411 Annapolis Road Odenton, Maryland 21113 ucinto 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) <u>Atherosclerotic Cardiovascular Disease</u> **Physician** /Medical Due to (or as a consequence of): Examiner Seizures Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Cerebral Palsy the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2X No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b rector, page 2 sl 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Germantown, Maryland 20874 19529 Doctors Drive Vinu Ganti . Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 25**

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Physician 9:22A M Walter Piaskowski Jr. Lanuary 21,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square Hospital OSCO Q If Under 24 Hrs. center If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Hours M 2□ F 215-64-8493 Dec.20,1955 52 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Baltimore Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 1715 Langley Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White þ Maryland 21/215-003 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) Contractor Builder 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Piaskowski Sr. Agnes Sobus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Piaskowski /brother 12 S. Durham Street Baltimore MD 21231 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 1/26/08 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Fun Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Inter the disease or compactions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 20 ear Due to (or as a consequence of): **Physician** resulting in death) /Medical Examiner iter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off Examiner The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) ___ Month Year Day in the past 12 months? ed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? be 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 No has death? 1 ☐ Yes 2 ☐ No 1□ Yes certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3□ DOA 1 Inpatient Medical Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined Hospital within 24 hours a
To the Funeral t 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

31. Date filed (Month, Day, Jear) State Registrar

29b. Signature and title of certifier

Hughes

30. Name and address of person who competed cause of death (Item 23a) (Type, Print)

32. Rafistrar's Signature

29c. License number

601 N caroline St. / THOC7143 Baltimore,

29d. Date signed (Month, Day, Year)

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Registrar

2

5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 12:50 AM January 22 2008 Patterson Linda /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs 3. Date of Birth Month, Day, Year) Apr 28, 1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🖫 F Yrs. 60 214-54-1209 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No **Funeral Director** Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number should be filed within 72 hours after death with USA 21742 19911 Jefferson Boulevard 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 21 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner mo 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify altimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Supervisor Housekeeping 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental P Be Mary Elizabeth Evans William P. Shytle ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Eugene N. Patterson (Spouse) 19911 Jefferson Blvd., Hagerstown, MD 21742 Health i Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H Important: If Ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State Springfield Cemetery: 1/24/2008 | Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License HAIGHT FUNERAL HOME & CHAPEL, P.A.Box 195) Sykesville, MD 21784 M00764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) Days **Physician** /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page perform 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tyes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: within 24 hours after ucc...
To the Funeral Director: Aft

State Registrar

Medical

4 Homicide

(Check only one)

29a, Certifier

Fauri Rizu, MD

and manner stated.

29c. License number

Street, Frederick 21701

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) January 23, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W 7+4 MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** 19, MARY RUTH RAY JAN 2008 7:14 AM /Medical 4a. Facility Name (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner CLEN BURNIE HEALTH AND REHABILITATION ANNE ARUMDEL **GLEN BURNIE** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 85 MARCH 6, WV 235.20.4064 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b, County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX Directo MD ANNE ARUNDEL GLEN BURNIE 10e, Street and Number 10g, Citizen of What Country? 10f. Zip Code 7355 FURNACE BRANCH RD 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give **XX** Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2XX No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 **TEACHER** RELIGIOUS SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ ink unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAMONA RUTH RAY SUTPHIN DAUGHTER 59432 GARCIA RD. BOONE, CO 81025 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 □Removal from State 30-08 MOVETCEM CROWNSVILLE 4 ☐ Donation 5 ☐ Other (Specify CROWNSVILLE, MD 22. Name and Address of Facility FINK FUNERAL HOME, P.A (red Europa Sarvice CRECORY M01148 426 CRAIN HWY S. GLEN BURNIE, MD 21061 23a. Par 1. Enter the Nice as shortk, or heart failure. vice ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Physician EMEN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform 1∏ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W201 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

Registrar's Sign

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mathuar V 23, 2008 **Physician** Shirley Margueritte Staehlin 5:38AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Examiner 4b. City, Town, or Location of Death Center Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec 25,1936 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🕅 F 71 Baltimore, MD. Director 213-34-8835 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d Inside City Limits Maryland Baltimore County Cockeysville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21030 United States 14 Jefferson Ave. 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes ŽŪNo Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Shirley M.Staehlin than Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Accountant Accounting & Tax Serv. n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Emma Blauvelt John Hurley Berwager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Cooleanseville Marvland 21030 19a. Informant's Name/Relationship (Type. Print) Mr. Carl William Staehlin (Hus.) 20a. Method of Disposition 20b. Place of Disposition (Name of GICCID OUT 15to (CEMP) Date Bartimore City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland **Funeral** Jan.24,2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium,Maryland 21093 11. Inter the lise se, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or mart fall re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG AND BONE METASTASES resulting in death) /Medical Due to (or as a consequence of): Examiner SPINDLE CELL NEOPLASM OF SACRUM Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month 4□Pregnant at time of death 5 Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy perform 1∐ Yes 2**X** No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3□ DOA ဥ 1 🔀 Inpatient 2 ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) D24034

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWSON.

MARYLAND

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Eugene, Thomas Stanley 3:17 PM 2008 JAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MERLY MEDILAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Oct. 28, 1953 1**X**M 2□ F Months Days Hours Min. 54 238-90-8754 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Baltimore Parvkille 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 Acton Road 21234 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or iter 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Post Office Letter Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Thomas Stanley, Sr Virginia Dare Harrell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. 3301 Acton Road-Parkville, Maryland 21234 Cheryl Stanley-spouse 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Parkwood Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Jan.26,2008 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,Maryland 21234 22. Name and Address of Facility EVANS FUNERAL CHAPEL andral AND CREMATION SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metestetiz Lun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transi and Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached for P.O. 1 Yes 2 TNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a Was an page 2 this certificate has autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? After or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No within 24 hours after death To the Funeral Director: 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical npletely (Check only one) and manner stated. 29b. Signature and title of/certifier 29c. License number 29d. Date signed (Month, Day, Year) JAN 21 2008

Registrar

PANL 6-1 KLUETZ 31. Date filed (Month, Day, Year) State

30. Name and addres

32. Registrar's Signature

St-Pewl

Ø\$ 66488

Baltinne

21201

ORIGINAL

n who completed cause of death (Item 23a) (Type, Print)

301

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year OS **Physician** Szczepanski 23 1159 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Mospital Baltimore, MD City, Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 2M 2□ F 68 218-36-7882 5,10, 439 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 2703 Reckord Road 21087 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Photographer Photography 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Szczepanski Cecelia Kmieciak ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Szczepanski/Wife 2703 Reckord Rd. Kingsville MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/25/2008 Baltimore Holy_Rosarv 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Artery Due to (or as a con uence of) disease or condition resulting in death) /Medical Examiner theroscierosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the bunial-tran Division or Vital Records, P.O. Box 68760,arphiDue to (or as a consequence of) attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Yes 2 No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Q

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 2 5

Neyman Borgher, MD

Keyman Borghei, MD. Good Samuritan Hospita 32 Registrar's Signature 12 Silver

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

KES 000

29d. Date signed (Month, Day, Year)

1/23/08

Amend #1, perMD, 876, 2/6/08 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #5,perFh,g875, 1/25/08 TT Certificate of Death Reg. No Sister Mary Rosary San Martin AKA Norberta San Martin Y Pan Sister Mary Rosary San Martin AKA Norberta San Martin Y Pan Sister Mary Rosary San Martin 2. Date of Death **Physician** Month Day /Medical 2008 1:18p. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 701 Gun Road Baltimore 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 214-64-9838 1 ☐ M 2 🛛 F Months Days Hours Min. Director 99 March 4,1908 Cuba Usual Residence of Decedent death with the Maryland show 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f shov Medical Exaπiner must be nottfled at Director 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **701** Gun Rd 21227 Costa Rica 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Maryland 21215-0036 1 ¥ Yes 2 □ No Specify. þ 3 Widowed 4 Divorced Cuban Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed with the alth and Mental Hygier Item 27 is marked other the other traumatic event, the 5 Years + 12th Grade Pastoral Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilario San Martin Flora Mia Pan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Ricardo Maddox Gun_Rd Catonsville, MD Important: If Item 2 any Injury or other 21227 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 1/29/08 Baltimore, MD | 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service License 21215 23a. Part1. Enter the disease, or complications that can be shick, or heart halure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congective Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Otheras burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death N/A
3□Ectopic pregnancy NA 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) ed by the a detached f signed by I be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1∐ Yes Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 □Other (Specify)
28d. Describe how injury occurred this 27. Manner of Death 28a. Date of Injury 28b. Time of After Hospital or Attending 5 Pending investigation Year) 1 Natural (Month, Day death. **2** ☐ Accident NIA 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) March 24 DAMIEN th Day, Year) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 4c per dr. 2875 01 / 25 08dhb

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** rover "/Medical 4b. City, Town, or Location of Death of Death Examiner Date of Birth (Month, Day. 9 Birthplace (State or Foreign **Funeral** 5-05-1969 Director MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show must be notified at BATIMORE MD ¥Yes 2 No Funeral Director 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country INNOR USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status "natural", or item edical Examiner r Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🔀 No Specify: Completed by 3 Widowed 4 Divorced th and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION MENTOR GED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nent of Health a SISTER CT. BATIMORE, MD · 2123 O
Date 20c. Location - City or Town, State ANNOR 20a. Method of Disposition

✓ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If it any Injury or conce. 1-19-2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility COMPASSION FUNERAL SCUS 119 S. STRICKER ST, BALTO, ND. 21223 21. Signature of Funeral Service Mu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical SS IF FFMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Be Completed by 1 Yes 2 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 2 10 24a. Was an certificate has autopsy perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 200 1 ☐ Yes Other: Certification: To 1 npatient 2 ER/Outpatient 3 DOA Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Accident Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Fafter death. (Month, Day Year) Injury 5 Pending investigation 1 Tyes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black indelible ink, Assure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year Physician SMITH RAYMOND Jan, 22 9:15P 216 2008 /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Vantage House Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) June 22,1927 Birthplace (State or Foreign Country) **Funeral** Months Days Min Hours 1 XM 2□ F Director Maryland 215 20 2082 80 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road #906 21044 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1951-52 1 Never Married 2 Married 1 ☐ Yes 2 No Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Marion C. Smith Jessie Lee Harrison ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Michael B. Smith/Son 6541 Belleview Drive Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of I important: if its any injury or of East New Market East New Market Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD. 2/9/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility M01044 Harry H. Witzke's Family FH Inc. Styly 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner LEU LEWIA Physician/Medical Examiner mphoce 1110 use es the bunel-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? funeral director, page 2 2 No 1 🗆 Yes 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? aGF 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) WUSE edical Certification; To 2 TUNO 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Menny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation iours efter death.

Neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled is 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Registrar

29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

30 Name and address of person who completed cause of death (Item 23e) (Type, Print)

BA

29c. License number

KENN

29d. Date signed (Month, Day, Year)

		Please	Type or Prin				-	_		
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Acceptance of the second		STELLA MARIS HO			TIMONIUM			BALTIMO		
Funera Directo			Sex 1 M 2 F 7. Age	80 Yı	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 08/01/	8. Date of Birth, (Month, Day, Year) 9. Birthplace (State Country) MD		
Maryland -f show fied at	tor	10a. State 10b. County MD BALTIM	ORE	10c. City, Town	OWINGS M	IILLS			10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 3743 BIRCH LANE	1	21117		10g. Citizen of What	Country?			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 17 Yes 2 1 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc.	
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and 2 lealth a m 27 is her train		SUSI STENGEL/	DAUGHTER		743 BIRCH			MILLS, ME		
Baltimore, permit. Pages 1 ar Department of Her mportant: If Item any injury or othe pres.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ARLINGT	Disposition (Name of Crematory or other place ON CHIZUK ONG	o1/2	4/2008	20c. Location - City BALTIMORE		
Ball permit Depart Import any in								SON & BROS		
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Records, P.O. Box 6876 The law requires that the death certificate by the has been signed by the attending physicionage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _			23d. Date of o Month	delivery Day Year	
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spita nours neral		29a. Certifier 1 Certifying F	hysician: To the best o	f my knowledge, o	death occurred at the tip	me, date and place,	and due to the	cause(s) and manner	as stated.	
To the Hos within 24 ho To the Fun completely	Medical	29b. Signature and title o certifier	and manner stat	ed.	29c. Licens	·		29d. Date signed (Mo		
P /			1-		Dy	3725			3108	
31		30. Name and address of person who		ath (Item 23a) (Ty	,	PTMONTING	MD 2104	0.3		
10	ate	DR. TARIO MAHMOO 31. Date filed (Month, Day, Year)	32. R egistra	r's Signature	4	rimonium,	ти Z10;	7.3		
Regis		JAN 2 5 2	UUB SUU	JA C	(Secret					

DHMH 17 Rev 1/2001

08-00576	
Ricky Taylor	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cky Taylor	State of 1- For State	of Maryland / Department of <i>Certificate</i>		201	08 0175
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		or Death	Reg. No. 2. Date of Death	3. Time of Death
ledical Examine	Ricky Daniel T	aylor, II		Month Day Year January 20, 2008	2107 hrs
MM .or.	4a. Facility Name (if not institution, give		4b. City, Town, or Location of Death	4c. County of Dea Howard	ath
Funeral	Howard County General Ho 5. Social Security Number 6. Sex				Birthplace (State or
Director			Months Days Hours Mir	Fore	
	Usual Residence of Decedent	VI 2 32	113.	03/10/13/0	, IN
w any	10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
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the Maryland a or 28a-f sh tified at onc	House of Correction	ons Road, PO Box 549	10f. Zip Code 20794	10g. Citizen of What Co	
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21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ' c event, the Medical To Be Complet				e (First, Middle, Maiden Surname)	
121 d be fill ental I arked sent,	Ricky Taylor	1		Hubbard Lawson	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Ty Amanda Taylor, Wi		•	Rural Route Number, City or Town, Standard Route Number, City or Town, Standard Rural Rura	
nore, MD 2 ages 1 and 2 shou at of Health and Int. If If item 27 is no other traumatic	20a. Method of Disposition	20b. Place of Disp	position (Name of cemetery,	Date 20c. Location - City	
Baltimore, permit. Pages 1 ar Department of Hee Important: If iteninjury or other tr		_ Itemoval II om State	other place) rty Cemetery 01,	/25/2008 Lebanon,	KY
Baltin permit. P Departme Importar injury or	4 Donation 5 Other Specify: 21. Signature in Furier Lervice Licens			ampbell-Dewitt Fur	
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the edical Certificati		 n: To the best of my knowledge, death oc On the basis of examination and/or investi 			
To the He within 24 To the Fu complete!	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. Date signed (
	Joeshe H	elmo	O.C.M.E.	January 21, 20	
	30. Name and address of person who co				
_		ssistant Medical Examiner 11	11 Penn Street, Baltimore, M	D 21201	
State	31. Date filed (Month, Day Year)	32. Registrar's Signature	60		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b.c per fh 9875 1-25-08 vt. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 8:30 **Physician** Patricia Ann Tallagsen January 20, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Baltimore Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛱 F 70 June 25, 1937 215-34-6601 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ıral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No MD. Harford Joppa Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 USA 1403 O. Joppa Forest Drive death Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: White Specify: 3 Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ratural", any injury or other traumatic event, the Medical Exa any injury or other traumatic event, the Medical Exa 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nora Eskew Bruce Greene 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Claret Drive Fallston, MD. 21047 Craig Vacovsky/ Son 20b Place of Disposition (Name of Greenmonn volume 125/08 Baltimore MD. 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Paro ful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, MD. 21093 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each time. 45 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit signed by the attending physician and deetached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 X No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been signification of the category of 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) HOSPICE Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After or Attending 5 Pending investigation 1 X Natural e Hospital or איי. יי 24 hours after death. ייי איז Director; Af 1 ☐ Yes 2 ☐ No М To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number hod 16 -21.05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. EDDIE NAKHUDA 31. Date filed (Month, Day, Year) State JAN 2 Registrar

p.m.

8:30

JANUARY

PATRICIA TALLAGSEN

21215-0036 altimore, Maryland M J

P.O. Box 68760,

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 22 **Physician** Month GLORIA LAFAY THUMEL January 2008 M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center ANNE ARUNDEL GLEN BURNIE Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M XX F Days Hours Min. Director 254.48.9245 SEPT 12, 1935 GA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location ns 23a or 28a-f show must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5 COUNTRY CLUB DR. 21060 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced "natural", or 1 ☐ Yes **XX** No Specify Specify. WHITE Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME Is marked other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ္ပ **ELLIS WALTER MULLIS** WILLIE HORTENSE SHEPARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA DENISE BUSH DAUGHTER 1634 BRAID HILLS DR. PASADENA, MD 21122 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ō Department of Important: If It Injury or 1 XXBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN CEMETERY 1.25.2008 GLEN BURNIE, MD 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. 21. Signal Funeral Service Lic CRECORY F FINK M01148 426 CRAIN HWY S. GLEN BURNIE, MD21061 23a. Pert1 Pert1 Enter the disease shock, or heart failure. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death cause on each line. Immediate Cause (Final disease or condition **Physician** irr hosi disease or condition resulting in death) ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Englished the Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of) ng physician as the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s 24a. Was an 2∐No 10 Yes Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Attending (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 49 87 14 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) u les harles min Washington y Registrar's Signature Gleu

State Registrar 31. Date filed (Month, Day, Year) 2008

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Hospital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:02P John F. Toomey III Januar 22,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oseda T91 8. Date of Birth OCt. 7, 1950 If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 157-38-1266 Months Days Hours Min. New York 1 XM 2 ☐ F 57 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Baltimore Baltimore 1 ☐ Yes 2X No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1622 Holly Tree Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental John F. Toomey II if Health and Menta Item 27 Is marked Sarah Cassel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1622 Holly Tree Road Baltimore, MD 21220 Barbara Toomey/ Wife Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I 1 ☐ Burial 2 ☐ Cremation 3 Pemoval from Injury or Bayview Crematory 01/23/08|Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu 22. Name and Address of Facility 300 Mace Avenue Baltimore, any 92 Connelly Funeral Home of Essex MD 21221 23a. Part . Enter the disease, or co so shock, or heart failure. List only o s that caused the be th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4001 disease or condition resulting in death) /Medical or as a consequence of): **Examiner** Sequentially list conditions, if any leading to him adate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ertension 24a. Was an page 2 autopsy perform certificate 1□ Yes or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Day funeral 28b Time of 28d. Describe how injury occurred After Year) 5 Pending investigation ours after death.
neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D65458

State Registrar

DHMH 17 Rev 1/2001

Square Drive Baltimore, Mp. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			= State Amend 7&8 perFH,g8	State of Maryland / De 175, 1/25/08 TT	epartment of H Certificate of L	Death	Re	g. No.	8 01758
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)	James Elloss	Wiley		2. Date of Death Month	Day Yea	a M
	Examin	_	4a. Facility Name (If not institution, give str		4b. City, Town, or TOWSOR	Location of Death	-	4c. County of De Baltin	eath
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth			8. Date of Birth (Month, Day,	Year 1912 9. E	Birthplace (State or Foreign Country)
	land ow It		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	e Mary Ba-f sh rtified a	Director		/A Baltin			1		1 Yes 2 No
	with the	I Dire	10e. Street and Number	Charles b	10f. Zip Code 2123	7	10	g. Citizen of What	Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	201 N. Washingt 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ON STYCET. 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Dio If Yes, GiveX X Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒️No		cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: B	
21215-0036	filed within 72 ho Hygiene. ther than "natur ent, the Medical I	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 5th grade	ation 16a. I College (1-4or 5+)	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired Cork	ation during most of workir d)	ng 1	6b. Kind of Busine Bethle	ss/Industry hem Steel
nd 2	be filed that Hygie of other event, the	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Surname)	
Maryland	should b and Ment s marked umatic e	T _o	Jim Wiley 19a. Informant's Name/Relationship (Type	e. Print) 19b.	Mailing Address (Street	Annie B and Number or Rura		City or Town, Stat	e, Zip Code)
	and 2 s lealth an m 27 is her trau		Bertha Bell - Da	ughter 1	400 E. Ma	dison St	reet	Balto,	ABt 21285
Baltimore,	t. Pa rtmer rtant: njury		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Arbut	Disposition (Name of crematory or other place) Memori 22. Name and Address	al 1-25	5-2008	Arbutus	
Ba	Depa Impo any is		Ximette,	K. Jones	1101 E	Mo North		Balto	
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not cause on each line. HEPATOCELL Due to (or as a consequence of	ULAR CA	RCNOM		st,	Approximate Interval Between Onset and Death Market
68760, 4	ficate be executed by physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	1):				
O. Box 687	eath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify) □	у		23d. Date of Month	delivery Day Year
rds, P.	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause giv	ren in Part I.	23e. Did tob		e to the cause of death?] Probably Unknown
or Vital Records,	The lay ate has page 2	Completed					24a. Was ar autops perforn 1 Yes 2	v I prior	e autopsy findings available to completion of cause of h? res 2 □ No
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes No Ho	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Oth	26. Place of Death		nce 6 Other (5	Specify) HOSPICE
ion or	ding I. After fune	ation: To	27. Manner of Death 15 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury 28b. T	ime of 28c. Injury Wor			w injury occurred	
Division	ial or Attenus after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Str City or Town	reet and Number o , State)	r Rural Route Number,
	e Hospital 24 hours a e Funeral C etely filled	edical (iclan: To the best of my knowledge, er: On the basis of examination and and manner stated.					
)	To the within 2 To the Complete	Med	29b. Signature and title of certifier		29c. Licens	se number 95643	29	Pd. Date signed (M	onth, Day, Year)
	5		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type, Print) Otmor	MD 21	204	4	
	Sta Regist		30. Name and address of person who cor 555 W. Towson 31. Date filed (Month, Day, Year) 200	32 Registrar's Signature	front			······································	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 4:04 P M 12 2008 CHARLES WAYLAND WEST JAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 11XM 2□ F Jan. 68 1939 Tennessee 411-60-2753 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County if Hoalth and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No **Funeral Director** Maryland Montgomery 01ney 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17601 Georgia Avenue 20832 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2☐No If Yes, Give Year or Dates: 1986 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗖 No Baltimore, Maryland 21215-0036 Specify: Specify: þ White 3 X Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief Petty Officer U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Jackson West Anna Frances Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5908 Vandegrift Ave., Rockville, MD 20851 Michael West (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 K Bunal 2 ☐ Cremation 3 ☐ Removal from State 1-18-08 Stone Dam Cemetery Chuckey, TN 5 Other (Specify) 4 □ Donation 22. Name and Address of Facility
Rose Hill Funeral Home, Inc. 21. Signature of Funeral Service Licensee 125 Idletime Dr., Greeneville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AMYOTROPHIC LATERAL SCLEROSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 □ No 2 💢 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0101236796 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER 20 MC USN M.A.FRANZOS LCDR 20889-5600 BETHESDA MD 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State JAN 25 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month 19, 2008 **Physician** January 4:45 P M Ward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 5, 193 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F 1932 0klahoma 443-38-6121 75 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County il Hygiene. . other then "nature!", or itema 23a or 28a-f ehow vent, the Medical Examiner must be natified at 1 ☐ Yes 2 ☑ No Directo Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 U.S.A. 4890 Battery Lane Pages 1 end 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1954 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 X Divorced 1954 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Nurse 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bez Wright John H. Allen ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 W.Cheyenne, Elreno, OK 73036 item 27 Leo Allen (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ō 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Depertment of Important: if any injury or once. Elreno Cemetery 1-26-08 Elreno, OK 4 Denation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Russworm Funeral Home 621 East Russworm Dr., Watonga, OK 73772 Momen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) 3 weeks **Physician** Anoxic brain injury /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): as the burial-Division of Vital Records, P.O. Box 68760, physicier Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diffuse alveolar hemorrhage, end-stage renal failure, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? diabetes, peripheral vascular disease, CAD, 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No cerebral ischemia 1 Yes 2K No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 🖔 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours en To the Funeral D completely filled in 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number tle of certifier 29b. Signature a D62949 1/19/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) b 8600 Old Georgetown Rd., Bethesda, MD 20814 Haag Natashq, MD 31. Date filed (Month, Day, Year) Registrar's Signalue State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g875, Q1/25/08dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Woodson Viola 13 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Jehns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdav) **Funeral** 1 M 2 F Months Days Hours Min. MARYTAND 68 Yrs. 216-34-5115 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f sh notified 1 X Yes 2 □ No Director BALTIMORE N/A MD. 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? rai", or Items 23a or Examiner must be r 21215 USA Funeral 4411 ELDERON AVE 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 2 Specify: BLACK 3 Widowed 4 Divorced "naturai", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE COMPANY MANAGER -12snould be filt th and Mental Hve 7 is mark 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILA GREEN HARRY BROWN SR. Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 4411 ELDERON AVE. BALTIMORE, MARYLAND 21215 WALTER A. WOODSON (HUSBAND) other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 □Removal from State Department o important: if any injury or = 5 GARRISON FOREST VETERANS 1-24-2008 OWINGS MILLS, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liger See JONATIAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 of 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multi 30 days disease or condition resulting in death) organ /Medical Due to (or as a consequence of): Examiner days Right heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Tricuspid Regurgitation burial-tran Due to (or as a consequence of): physician the burial Physiclan/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 | Yes 2 | No 3 | Probably 4 | Whitehown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No certificate 2 No 1 ☐ Yes Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 9 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospitai or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Januar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Street Wolfe Michael eme. 600 31. Date filed (Month, Day, Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** WILLIAM CARR WALLER JANUARY 2008 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner B Anne Arundel 61en Baltimore washington medical center UCAC 8. Date of Birth (Month, Day, Year NARCH 24, 15 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 FL Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1**XX**M 2□ F 263.50.1298 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 □Yes 2 No Director ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with items 23a 199 PLYMOUTH LA APT D USA 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or iten filed within 72 hours after or Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 53-83 WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOATSWAINS_MATE_FIRST_CLASS UNITED STATES NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 JAMES WALLER ELISE SULLIVAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA WALLER WIFE 199 PLYMOUTH LA APT D CLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State MDVETCEM CROWNSVILLE 4 Donation 5 Dother (Specify) 11.22.2008 CROWNSVILLE, HD GREGORY FINK 22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY S. CLEN BURNIE, ND 21061 M01148 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Enter the 23a. Part shock, or heart fall Immediate ause (Final disease or condition resulting in death) Due to (or a consequence of): Physician /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2□ No 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manus of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier My 94781 wiles mi) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) howhas 301 Hospital Drive Medical Center more 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 am Sun Yi Yi Januar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ital STIMORE Jakyland Gr If Under 1 Year 3. Date of Birth (Month, Day, Year) 06/20/1923 Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F 218-08-7818 84 Korea **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show If Item 27 is marked other than "natural", or Items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No N/A Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2139 Pennsylvania Avenue 21227 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 ☐ No Specify: Asian ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sok Jin Yun Cho Katni 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jyong Ja Yun (Daughter) 2139 Pennsylvania Avenue, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 01/26/2008 Baltimore, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc any Mark T. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the diseas per complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) THUMON /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 ☐ Unknown <u>۾</u> signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Yes cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 1 No 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 🗌 Yes 2 □ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) telt Sunt 103 N. Eutaw 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 6 Lloyd Bruce Amos /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Doctors Hospital Prince George's Lanham Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 1**∑**M 2□ F 70 Yrs. Director 577-52-3126 02/13/1937 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other than many Injury or other traumatic event, the Medical Examiner must be notified at 1.☐Yes 2☐No Director Maryland | Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12100 Reardon Lane U.S.A. 20715 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1777es 2 No If Yes, Give Year or Dates:54-58 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2**XXX**No Specify Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Clerk U.S. Postal Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ferdinand Amos Thelma Brooks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice V. Amos /wife 12100 Reardon Lane, Bowie, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mary Land Veterans XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/14/2008 Crownsville, MD Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Respirator /Medical Due to (or as a consequence of): **Examiner** retebolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Adllance ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 sepsis Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yes 2 □ No 3 □ Probably 4 □ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 2Z No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Menu 117108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alemu 8118 Good Luck Rd., Lahham, md. 20706 31. Date filed (Month, Day, Year) State 2008 Registrar

			For	aryland / Depa			Mental Hyg	giene		
			1 - State Registrar	Ce	rtificate of	Death	2. Date of Dea	Reg. No.	08-	01765
	Physici	an	Decedent's Name (First, Middle, Last) Carl Edward Abend				Month	Day	Year	10 - FF M
-	/Medic	or left	4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Deat	January	9 2008 4c. County		10:55 p ^M
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	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		ce (State or Foreign
	Director		220–36–0912 [™] м 2□ F	67 Yrs.	Months Days	Hours Min.	oct. 31	, 1940	Mary	
-	pu:		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d	I. Inside City Limits
	faryla shor	5	MD Dorchester	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Madis	son				1 ∐Yes 2√∑No
\mathcal{Q}	the N 28a-1 notiffi	rect	10e. Street and Number	<u> </u>	10f. Zip Code			10g. Citizen of W	/hat Country	/?
R	h with 3a or st be	Funeral Director	1107 Taylors Island Road			21613		U	SA	
2	deatl	ner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)		- American	
36/	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	by Fu	1 Never Married	No	1 ☐ Yes 2 ☐XNo	Specify:	,	Specify:		
21215-0036	72 hou natura ical E	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup		rkina	16b. Kind of Bu	siness/Indus	stry
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Maryland	be de	Be	17. Father's Name (First, Middle, Last) Carl Albert Abend				ne Heise		B)	
Ž	2 should be and Menta is marked	٩	19a, Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street				State, Zip C	ode)
Ma	0 00 m		Bonnie Abend wife	1	Taylors			•		
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition	20b. Place of Dispo		i	Date	20c. Location -		n, State
E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	y Cremato	i .	4/08	Salisb	ury, M	ND
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee		2. Name and Addre		homas Fu	neral H	ome P.	Α.
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0 0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Inju 1 X Natural 5 ☐ Pending (Month, Da	ry 28b. Time o y <i>Year)</i> Injury	Wor		28d. Describe h	ow injury occurre	ed	
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	f examination and/or in						
	Vithin Within To th	Me	29b. Signature and title of certifie		29c. Licens			29d. Date signed	(Month, Da	ay, Year)
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	Di		30. Name and address of person who completed cause of d							
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	Sta Registi		31. Date filed (Month, Day, Year) 32. Regis	ar's Signature	Annall .					
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year David Byrlin Adams 1:17 PM 3008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/16/1924 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1 X M 2 □ F 217-12-2989 83 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washingtoh Hagerstown 1X Yes 2 □ No 10e.Street and Number 268 S. Potomac Street Street and Number 10g. Citizen of What Country? US 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Robert Adams Mazie Sedelia Stover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Smith, Case Manager 140 W. Franklin Street, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Smithsburg Crematory | 01/12/2008 | Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licens 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lock Due to (or as consequence of): 2, vos Sequentially list conditions, if any, leading to himboliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hiscon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2ŪNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2[17 No 1 🛂 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical **Examiner**

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

or Attending Physiclan:

Hospital

permit. Pages Department of Important: If its any injury or o

Physician

/Medical

Examiner

MD

Director

Funeral

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ral", or Items 23a or 28a-f shov Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit signed by the a

Physician/Medical Completed by Be Certification: To

After this certificate has been sifuneral director, page 2 should No the Prospose.

Within 24 hours a ler death.

To the Funeral Director: After this certific:

'----' filled in by the funeral director,

Medical the

OH-0+1

Registrar

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 2 Accident 3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title

29a. Certifier

5 Pending investigation

6 Could not be determined

(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 11,08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of perion who completed cause of death (Item 23a) (Type, Print)

Hagerstown, MD 21742 AU-C

31. Date filed (Month, Day, Year) **JAN 14** 2008 strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan	•	artment rtificate				ien <u>e</u> (og. No.	000	01/07
	*		1. Decedent's Name (First, Middle, Last)						2. Date of Deat	Day	Voor	3. Time of Death
R.	Physici /Medic		Fred Burnette Bear	den, Jr.					January	[□] შ7	2008	12:48 P M
	Examin	er	4a. Facility Name (If not institution, give s					cation of Death			ounty of Death	-
		ge ge	Anne Arundel Medica			Annap				Ann	e Arund	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Birth Month, Pay 07/25/19	Year)	9. Birthe Cour Texas	place (State or Foreign ntry)
	Director		438-18-0209 Usual Residence of Decedent		84 Yrs.				01/23/19		Texas	•
	land ow Et		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
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	r 288	Irec	10e. Street and Number			10f. Zip C	Code		1	-	n of What Cour	•
	th wit	Funeral Directo	85 Manresa Road			214	02			Unit	ed Stat	es
	ems erms	Iner		Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decede If Yes, specif	nt of Hispar ly Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
36	or it	γFL	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No WW If Yes, Give	III	1 ☐ Yes 2[X No S	pecify:		S	pecify: Whi	ite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show the Modleal Exercifier must be notified at	Completed by	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual	Occupation	n		16b Kind	of Business/In	
 2	in 72 n "na hedic	olet	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	done durin retired)	ng most of work	ing			
212	J with	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Manuf	acture	Repr	esentat	ive	ood	Service	9
פַ	other vent,	Bec	17. Father's Name (First, Middle, Last)						e (First, Middle, M	Maiden Su	ımame)	
Maryland	uld b Ments rrkad rttc e	ToE	Fred B. Bearden, Si	•				Gladys	UNKNOWN			
au	2 sho and is ma		19a. Informant's Name/Relationship (Type						al Route Number			
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0	t of h		20a. Method of Disposition 1 🗆 Burial 2 🛣 Cremation 3 🗆 Re	emoval from State	emetery, crei	matory`or oth	ner piace)	l .	9/2008		,	
Baltimore,	rtmer rtant rtant njury	li	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Final Se License		las Cr			1	orge P. I			
B	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then 'natural', or items 23a or 28a-f show any njury or other traumatic event, it a Madical Exercical mast be notified at once, not not not not not not not not not not		21. Signature Parties						nd Rd.,E			
7	4.		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not ent	er the mode	of dying, su	uch as cardiac	or respiratory arre	est,		Approximate Interval Between
a	Physician		tmmediate Cause (Final disease or condition	arcute or	u Ch	ronie		ngrico	1 Har	1/ /	derre	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):		117	11		0		
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0	he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	leath 5[Other (spe	cify)		· · · · · · · · · · · · · · · · · · ·		WIOITH	Day 1 bai
<u>P</u>	d by I		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	andertving ca	uso awan in	n Part I	23e Did tot	nacco use	contribute to t	he cause of death?
ds,	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use a	d by	Tatti, ottor significant conditions con	and the death but not not	oung in the c	moonying ou	aso givoir ii	T GIV I.			No 3∏Proi	1
Records,	w requir been si should	Completed							24a. Was a	0	24h Were autr	opsy findings available
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	Physician: The this certificate ha	To Be	ayaminer?	ospital: 1 2 stient 2 🗆	ER/Outpatie	nt 3 DOA	Other		ome 5 Reside		Other (Speci	(v)
Division of	g Phy ler this		27. Manger of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury at Work?		28d. Describe ho			
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<u>≅</u>	if or Attend after death Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory,	office	and the state of t	28f. Location (St City or Town		Number or Run	al Route Number,
Ω	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certification filled in by the funeral director,		200 Codifier	Idian To the hear of	oudodes de la	h accorded	t the to	data and stars	and due to the -	31180/s\ : :	nd manner to	etatod
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical		ician: To the best of my knower: On the basis of examination and manner stated.								
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<	% 66,75		30. Name and address of person who						1		0	/
	> 175		Michael J. LaPenta	, M.D., 445 D	efense	High	way, A	Annapol	is, Mary	land	21401	
25	Sta	ite	31. Date filed (Month, Day, Year)	32. egistrar's Signa	ature ——	1-						

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

32. Reastrar's Signature

JAN 0 9 2008

Neil

vanter held RD 6/2 Burne ms 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Evelyn B. Brown 2:13 A M 07, 2008 Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 02,1923 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 84 227-28-6312 Director Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-t show other traumatic event, the Medical Examinar must be notified at Severna Park 1 ☐ Yes 2 No Anne Arundel MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21146 506 St. Martins Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No II Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 💢 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha Welden Carroll Hansford D. McCrory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 506 St. Martins Lane Severna Park, MD 21146 Vernon J. Brown/ Husband Date 10, 20b. Place of Disposition (Name of cemetery crematory or other place)
Glen Haven 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 2008 Memorial Park 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Fy Approximate Interval Between Onset and Death 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician NUMOCArd disease or condition resulting in death) /Medical Due to (or a s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Physician/Medical detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deatb-but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Dinknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 20 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient OOA. 1 Inpatient 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide determined

The taw requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. physician the attending þ s been signed b should be deta certificate or Attending Physician: this After death. Director: filled in by after 24 hours a

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated Signa (re and title of certifie 29d. Date signed (Month, Day, Year, 29c. License number

completely

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30. Name and address of person who completed cause of death (Item 23a) (Type,

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within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:55 PM Thomas Beline 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland
5. Social Security Number 6. Sex Baltimore Medical Center N/A1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months M 2 ☐ F 061 05 2728 93 Director Mar.8, 1914 NORTH CAROLINA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Howard Columbia 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 7070 Cradlerock Way Apt. 420 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Affiled Forces? 1 XYes 2 No1942— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black ò 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) it of Health and Mental Hygiene. If item 27 Is marked other than or other traumatic event, the M Toll Booth Clerk New York Transit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Beline Carrie Cromatie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Nix/granddaughter 7472 Sea Change Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or Maryland Veteran's C. 1/14/2008 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD M0144221. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pk. Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi/c or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CERTIFICATION APPRIORED BY WITHOUT ENAMINEE **Physician** Multiple Injuries disease or condition resulting in death) /Medical Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No certificate To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 □ Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) L₀ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Subject was pedeswian swuck By ANTO 5 ☐ Pending investigation 930 pM 108 1 ☐ Yes 2 Mo 16 2 Decident 6 ☐ Could not be 3 ☐ Suicide 28e. Plat e of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide COLUMBIA, MO Cradle ROCK Way 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) all AU4176435 M16-773

State Registrar 31. Date filed (Month, Day, Year) JAN 1 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KASWA MAUL 22 South 22 32. Registrar's Signature

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Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	laryland / [artment o			lental Hy	/gien Reg. N	2000	01771
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	Physic /Medi		Victor Martin	Berke						Month Januar		ay Year • 2008	9:15 A M
j. v koj	Exami	ner	4a. Facility Name (If not institution	, give street and number)		4b. City, Tov	vn, or Location	on of Death		4	c. County of Death	
			43 Longmeadow D: 5. Social Security Number		ge (In yrs. last bir	thday)	Gaithe If Under 1 Y		g ler 24 Hrs.	8. Date of B		Montgomer	2
100	Funeral Director		092-05-1991	1 X M 2□ F		Yrs.		ays Hour		Month, D	ay, Year	r) Coui	place (State or Foreign htry) York
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits
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	th the or 28a e noti	Director	10e. Street and Number				10f. Zip Co	de			10g. C	itizen of What Cou	ntry?
	ath wi	ral	43 Longmeadow D	rive			20878				USA		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 🛣 Widowed 4 □ Divorced	12. Was Decedent Armed Forces 12 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. P No 1941–45		Vas Decedent fYes, specify □Yes 2X			ecify Yes or N Rican, etc.)	0-	14. Race - Americ Black, White, Specify:Whit	etc.
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land	should be fi and Mental H s marked oth	To Be	17. Father's Name (First, Middle, L Louis Berke	Last)					ther's Name e Free	<i>(First, Middle</i> eman	e, Maide	n Surname)	
Mary	1 and 2 should be filed v Health and Mental Hygie em 27 Is marked other t wther traumatic event, th		19a. Informant's Name/Relationsh Barbara Schwart		ter 66	. Mailin	g Address <i>(St</i> Paxton	reet and Nur Road	nber or Rura Rockvi	il Route Numb	per, City	or Town, State, Zip	Code)
Baltimore, Maryland 21215-0036	Pages 1 and of He	1 2	20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of cemeter Chesa	Dispos ry, cren nea	sition (Name of hatory or other ke Cren	f place) natory	1)/08		ocation - City or To	*
Balt	permit. Page Department Important: If any injury o		21. Signature of Funeral Service L	the Oth	 _ MO1251	Go Be	Name and Acoing Ho everly	ddress of Fa ome Cr L. He	cility ematic ckrott	on Serv	rice . C.	P.O. Bo larksvill	x 784 e, MD 21029
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	stan: ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Pla	ce of Death	(Check only of		1 ☐ Yes	2□ No
20	hysic this ce	၉	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpati			2 DOV		Nursing Hon	ne 5. X Resi	dence	6 □Other (Specify	y)
101	or Attending Physician: after death. Director: After this certific in by the funeral director,	ation:	27. Manner of Death 1 Natural 5 Pending investiga	ation		ime of njury		njury at Work? I∐Yes 2[i	8d. Describe	how inju	ry occurred	
	tal or Att s after de al Directu ed in by t	Certification:	3 Suicide 6 Could no 4 Homicide determin	ned 28e. Place of inj	ury - At home, far c. <i>(Specify)</i>	m, stre	et, factory, offi	ce	2	8f. Location (City or To	Street ar wn, State	nd Number or Rura e)	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	f <i>e</i> xamination and	death dor inv	occurred at th	e time, date	and place, a eath occurre	and due to the ed at the time,	cause(s date an	and manner as st d place, and due to	tated. o the cause(s)
	To t To t	Ž	29b. Signature and title of certifier	Wad B	Lind	7	29c. Lic.	ens <i>e</i> numbe	r			ite signed (Month, a	
0	£1)02		30. Name and address of person w				rint)						
West of	Sta	e	Génevieve Wroble 31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			e KOC	∨∧TTT€	, MD 2	UODL) 	
	Registra		JAN 1 0	2008	se &	A	anti)						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Leroy Commodore January 2008 12:15A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Edgewater Anne Arundel Millennium-South River Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1X M 2□ F Director 88 September 4, 1919 Maryland 216-12-4044 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Director MD Calvert Port Republic 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20676 Funeral 1832 Parkers Creek Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 (2) Yes 2 | No 1943
If Yes, Give
Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. þ 3√□ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Cement Finisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked or ပ Harry Commodore **Nettie Gross** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Osprey Lane Lusby MD 20657 Nicole Brooks - Niece or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o 4 ☐ Donation 5 ☐ Other (Specify) Brown's Cemetery 1/11/2008 Port Republic, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Sewell Funeral Home, 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosc) enotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Advance Jas autopsy performed death? certificate Acute Rena 2□No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 27. Manper of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrans Signature

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08-00515 Jane Claire Cooke

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		I- For State Registrar		С	ertifica	ate of	Death				F	Reg. No.	UU	0 01/1
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-		4a. Facility Name (if not institutio	-			41	b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel							
		Baltimore Washington	Medical Cente	er 										
Funeral	٦	5. Social Security Number	6. Sex	7. Age (In yr	s. last birt	hday)	If Under					irth (MM/DD/YYY)	Transier	_
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director / completely filled in by the f.	Certification:		mined (Specify)							or Town,	State)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008^{ear} Helene S. Colegrove January 7 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare, Spa Creek Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF 215-22-5785 87 May 30, 1920 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10h. County 10d. Inside City Limits r 28a-f show notified at 10a State Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 622 Rolling Dale Road 21401 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIII Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Co-owner Hardware Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Schott Jennie (unknown)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Crematory

Рм

Physician /Medical Examiner

item 27 I

Department of Health Important: If item 27 any Injury or other tr

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19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee

20a. Method of Disposition

Brightsie Stroud/friend

1 ☐ Burial 2 ★ remation 3 ☐ Removal from State

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Exam
an/Medical
ed by Physiciar
mplet
To Be Co
Certification:

Jodd	E Nulle 147 Duke of Glouceste	r St., Annapolis	, MD 21401
shock, or heart failure. List on Immediate Cause (Final	inplications that caused the death. Do not enter the mode of dying, such as cardiac or rely one cause on each line.	espiratory arrest,	Approximate Interval Between Onset and Death
disease or condition resulting in death)	Due to (or as a consequence of):	7 (14
Sequentially list conditions, if any, leading to immediate	b		
resulting in death) Last	cDue to (or as a consequence of):		
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of de Month	olivery Day Year
art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
		autopsy prior to performed? death?	utopsy findings availab completion of cause of s 2 \(\square\) No
25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home	5 ☐ Residence 6 ☐ Other (Spe	ecify)
7. Manner of Death 1 → atural 5 Pending 2 Accident investigati	(Month, Day Year) Injury Work?	f. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		Location (Street and Number or Fi City or Town, State)	ural Route Number,
29a. Certifier (Check only one) 1 Certifying I	httpsiclan: To the best of my knowledge, death occurred at the time, date and place, and miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner a at the time, date and place, and du	s stated. e to the cause(s)
29b. Signature and title of cellifler	29c. License number 8 3 2 1 3 ¢	29d. Date signed (Mon	th, Day, Year)
30. Name and address of person wh	o completed cause of death (Item 23a) (Type, Print)	1)//	1 15

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

1/9/2008

22. Name and Address of Facility John M. Taylor Funeral Home

20c. Location - City or Town, State

Baltimore, Maryland

21619

700 Carlisle Drive Arnold, Maryland

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year,

JAN 0 9 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09 Naomi Elizabeth Guildford Caldwell Facility Name (If not institution, give street and number 4c. County of Death Coasta Wicomico 5. Social Security Number If Under 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🗓 F 81 579-28-8425 Washington, DC Mav 1926 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland | Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5437 Loch Ness Terrace 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Guilford Mary Elizabeth Waters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin J. Caldwell, Jr./Son 5437 Loch Ness Terrace, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/14/2008 Beulah, Maryland 21. Signature of Funeral Service Lice. Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 exa. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIINPARCT Due to (or as a consequence of): BREBROVASCULA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown ath? nknown vailable ise of

Physician /Medical Examiner Examine

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; if Item 27 is marked other than any lajury or other traumatic event, the once.

Physician

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimoré,

event, the Medical Examiner must be notified

Director

Funeral

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Completed

Be

/Medical

requires that the death certificate be executed and burial-tra attending physician for use as the buria signed by the sign of the sign page 2 or Attending

Physician/Medical

Be Completed by

Certification: To

Division or Vital Records, P.O. Box 68760

Part II. Other significant conditions	contributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacco us	se contribute to the cause of de
				24a. Was an autopsy performed?	24b. Were autopsy findings a prior to completion of cardeath? 1 □ Yes ♣ No
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 ☐ Yes 2 ☐ 16	Hospital: 1 Phopatient 2]ER/Outpatient 3 ☐ [DOA Other: 4 Nursing	Home 5 ☐ Residence 6	□Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, facto	ory, office	28f. Location (Street and	Number or Rural Route Numb

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one)

29b. Signature and little of certifier

DO058410

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hungan WARG COASTAL

P.O BOX 1733 SAGISBURY UD 21802

State Registrar

24 hours after death Funeral Director: filled in by the

To the

Hospital

HOSPICA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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caminer	4a. Facility Name (If not institu Randolph Hi				4b. City, Town, or Wheaton	Location of	Death			. County of Death Montgome	
eral ector	5. Social Security Number 579–44–4212	6. Sex 1 ☐ M 2 ☐	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	8. Date of Bi Apprin D	rth av Yearl	9. Birth	place (State or For
	Usual Residence of Decedent						4	pril i	4, 1	932 Wash	ington,
d at	10a. State 10b. Cou	ntgomery		ty, Town or Lo	ocation						10d. Inside City Li
be notified Director	10e. Street and Number	negomery	WI:	eaton	106 75- 0-1-				40 011		x Yes 2□
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event Be (17. Father's Name (First, Midd							(First, Middle		•	
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traur	19a. Informant's Name/Relation Robert Cardos				ng Address <i>(Street a</i> Underwood						
other	20a. Method of Disposition		20b. F		sition (Name of matory or other place			ate		ocation - City or To	
any injury or other traumatic event, the Medical Examiner must be notifiled at once. To Be Completed by Funeral Director	Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		ulli State		natory or other place n Veteran :		18-2	2008		tenham, N	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Henry Thomas Chatham, II January 8, 2008 5:41p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Hospital E1kton Cecil 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠** M 2□ F Months Days Hours Min. 67 219-36-5191 Jan. 22, 1940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No MD Cecil E1kton 10e_Street and Number Laurelwood Care Center 10f. Zip Code 10g, Citizen of What Country? U.S.A. 411 North Bridge Street 21921 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1959 1 X Never Married 2 Married 1 ☐ Yes 2XX No Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Never Worked</u> None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua Thomas Chatham Mildred Mae Donoho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne C. Hearn (Sister) P.O. Box 524 Delmar, DE 19940 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery Jan. 12, 2008 Salisbury, Maryland 21. Signature of Funeral Service Licencee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE 23a. Part1. Enter the disease, or com-shock, or head-ailure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Immediate Cause (Final disease or condition resulting in death) and o surpersalons Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the M

Physician

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Examiner

Director

Funeral

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Completed

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show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine

burial-trar attending physician the After 1

the death certificate be executed

Division or Vital Records, P.O. Box 68760.

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

State Registrar 29b. Signature and title of dertifier

NiTIN

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ERAID

2008

	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □ Ectopic			23d. Date of delivery Month Day Year				
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		co use contribute to the cause of death?				
				24a. Was an autopsy performed 1 Yes 2 ✓					
25. Was case referred to medical examiner?			26. Place of De	eath Check onl one					
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2]ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)				
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred				
3 Suicide 6 Could not t 4 Homicide determined		iome, farm, street, factorify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier 1 Certifying P	hysician: To the best of my knimer: On the basis of examin	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)				

29c. License number

DOO 66

ribus-

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

BOW

istrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		State		artment of Health and M	•	•							
		1 = For State Registrar		rtificate of Death	_	2008	01778						
	. 杨 《	Decedent's Name (First, Middle, Last)	-		2. Date of Death		3. Time of Death						
Physi /Med		Robert Lee Elzey			January 1	0 2008	6:30 A ^M						
Exam	iner	4a. Facility Name (If not institution, give street and no	,	4b. City, Town, or Location of Death		4c. County of Death							
(w etc	Chesapeake Woods Centors 5. Social Security Number 6. Sex	er 7. Age (In yrs. last birthday)	Cambridge If Under 1 Year If Under 24 Hrs.	9 Date of Righ	Dorchest							
Funera		213–30–9372 Usual Residence of Decedent	74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 13,	1933 Mary	ace (State or Foreign r) rland						
how		10a. State 10b. County	10c. City, Town or Lo			10	d. Inside City Limits						
28a-1-i	Funeral Director	MD Dorchester 10e. Street and Number		Cambridge	100	Citizen of 18th at Count	1 XYes 2 No						
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dea dea	iner	11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	city Yes or No-	14. Race - America Black, White, e							
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21215-0036 de within 72 hours aft giene. or than "naturet", or the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed,	(Give	dent's Usual Occupation kind of work done during most of workit DO NOT use retired)	ng 16b.	Kind of Business/Indu	ustry						
212 d with	mo.	Elementary/Secondary (0-12) College (1-401 5+)	cargo handler		port							
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Mudical Examinat must be notified as	To Be (17. Father's Name (First, Middle, Last) Robert L. Elzey		18. Mother's Name Della V	(First, Middle, Maid Iroten	en Sumame)							
ary shou and M e mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailie	ng Address (Street and Number or Rura	l Route Number, City	y or Town, State, Zip (Code)						
and 2 and 2 ealth n 27 I	T			Glenburn Ave. Apt.	305, Cam	bridge, MD	21613						
Baltimore, Dermit. Pages 1 ar Department of Hea mportant: If Item:		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	State	matory or other place)		Location - City or Tow							
ti Pa rtmen rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify)	Dorcheste	er Mem. Park 1/12/		mbridge, M							
Dermi Depa Impo		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Th. 700 Locust St., Cam		ral Home P D 21613	.A.						
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Records, he law requires t e has been signe tge 2 should be o	mplet	Hypoclipidemia,	Per: Pheral	VASCULAR	24a. Was an autopsy performed?	prior to comp	sy findings available pletion of cause of						
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ysici ysici is cer direct	To B	examiner?	npatient 2 ER/Outpatien	26. Place of Death Other: 4 Surviving Horn		6 ☐Other (Specify)							
on of Vital Reding Physicien: The Information The Information The Information		27. Manner of Death 28a. Date			8d. Describe how in								
SIO tendii leath. tor: A	catio	2 Accident investigation		M 1 Yes 2 No									
DIVISION Of VITA Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certificinel filled in by the funeral director.	Certification:	determined 200. Place	of Injury · At home, farm, str ng, etc. (Specify)	eet, factory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural I ite)	Route Number,						
DIVISIO To the Hospitel or Attend within 24 hours after death To the Funerel Director: A completely filled in by the th	edicai (2 modical Examiner. On the o	best of my knowledge, death asis of examination and/or inverstated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cause(d at the time, date a	(s) and manner as stated and place, and due to the	ed. he cause(s)						
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Da	ay, Year)						
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Ч		30. Name and ordess of person of completed cause		Print)	<i>(</i> 1)	1.1.							
	- 45	B1. Date filed (Month, Day, Year) 32. F	100 egis d's Signature	Bransie St	(An	- Dr.dse							
Regis	ate trar	JAN 1 1 2008	Syllature A	Small									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Mary Ellen Ebersole 2008 1245 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 05/05/1954 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 220-58-3745 53 Director Usual Residence of Decedent 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Washington Hagerstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 Berner Avenue 21740 HS Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 ☐ Never Married 2 X Married White Completed by 1 ☐ Yes 2X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical i 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson Pershing Bryan, Sr. Bertha Catherine Shatzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Berner Avenue, Hagerstown, MD 21740 19a. Informant's Name/Relationship (Type. Print) Thomas L. Ebersole, Sr./Husb. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 01/15/2008 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician meterte disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if city, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for as a consequence of) Examiner Due to (or as a consequence of): burial-tran attending physician Physician/Medical use as the IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy ō Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death detached the 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2□ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident Funeral Director: tely filled in by the 3□ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

16H-2

To the Hospital or Attending Physician:

hours after

within 24 P

Baltimore, Maryland 21215-0036

be executed

been

this certificate

After

Box 68760.

P.0.

Division or Vital Records,

State Registrar

Medical

31. Date filed (Month, Day, Year) **JAN 14**

29b. Signature and title of certifier

JAROSLAW

Co, Man

KALKA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29a. Certifier

(Check only one)

Fest 251

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

1/4/2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Robert J. Einhorn Robert J. Ein			1 - State Of IVIA State Registrar		ertificate of L		лептат пу	Reg. No.	2000	01780	
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	MY		30. Name and address of person who completed cause of do	eath (Item 23a) (Type		C T O T O		Ja	inuary 13	2000	
Genevieve A. Wroblewski M.D. 1355 Piccard Drive, Rockville, Maryland 2	D		/-			rd Drive,	Rocky	ville	, Maryla	and 20850	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 1.0.0.1 1.4. 2008				ar's Signature	barle						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frances В. Free 2008 January 4:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Months 220-36-8307 June 13, Director 100 1907 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits show at r 28a-f sh notified 1 Yes 2 □ No Director Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 318 North Main Street 21771 U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If then 27 is marked other them any injury or other trainments. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 9 Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary Elementary/Secondary (0-12) College (1-4or 5+) Teacher, Vice-Principal School School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be William Bellison Hyatt Amv ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline C. Richards - Niece 1101 North Main Street, Mount Airy, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 1/16/08 4 □ Donation 5 □ Other (Specify) Mount Airy, Maryland 21. Signature of Fu eral Service Licensee Molesworth-Williams P.A., Funeral Home hour 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a con-equence of) disease or condition resulting in death) /Medical Examiner unn Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician the aftending p for use as use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, p 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perforn or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Year (Month, Day 1' Natural 5 Pending within 24 hours and worth 2 Accident Investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of ceptific 29d. Date signed (Month, Day, Year) 126499 January 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D. #4 Culwell Drive, Mount Airy, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar 14

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Goldie Mae Gearhart lanuary 2008 302 AM /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Washing Washington County Hospital If Under 1 Year of Under 24 Hrs. 8.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Feb 12, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕅 F 84 165-26-6567 PA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show a or 28a-f show be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Hagerstown MD Washington 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 937 Concord Street ral", or items 23a Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelly May Mickley Paul Nicewander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 937 Concord St., Hagerstown, MD 21740 Kathy R. Davis daughter : If Item 27 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Antrim TWP permit. Page Department o Important: If any injury or once. 01/18/2008 Macedonia Ch Cem. Franklin Co., 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Bowersox Funeral Home James (i. Ben Vorsey 521 S. Washington ST., Greencastle, PA 17225 23a. P rt1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final **Physician** ardiopenu disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially liet consilioner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and sthe burial-trans Due to (or as a consequence of) Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Yea 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA this illed in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural (Month, Day Year) 5 ☐ Pending investigation after death. 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide TEA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

> State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

numma

176

29c. License number

01-14-2002

and manner stated.

MO

32. Régistrar's Signature

mame and address of person who completed cause of death (Item 23a) (Type, Print) eem

NUC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Jean Wildbore Gray , 2008 02:45 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood at Williamsport Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 579-24-9832 1/14/1925 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐Yes 2 No be notified Directo <u> Maryland | Washington</u> Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a must 13091 Little Hayden Circle 21742 U.S.A. Funeral 14. Race - American Indian, or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or item ury or other traumatic event, the Medical Examinea ury or other traumatic event, the Medical Examinea 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Maurice Stewart Wildbore Annie Matthews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gray Jones/ Daughter 12835 Unger Rd. Smithsburg Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Irvington, Historic Christ Church 1/14/2008 Virginia 21. Signature of Funeral Service License Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an ach jine. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknow þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of perform death? 1 □ Yes 2 □ No certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 1 Tyes 2 ER/Outpatient 3 DOA 2 1 ☐ Inpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 🗆 No investigation Director; / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) To the ...
To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

BH-4

State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature a

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of N State Amend #9 per FH 01-	/laryland / 22–2008	Depa CNM C	artment of H rtificate of L	ealth and N Death	lental Hyوا ا	giene Reg. No.	2008	0178	} 4
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*	Physici /Medio		Alfa Giacchet	rti				Month January	Day	2008	2:05 P	М
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			Frederick Memorial Hospi	ital		Fre	derick			Fred	lerick	
1	Funeral		5. Social Security Number 6. Sex 7. /	Age (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v Year)	9. Birth	place (State or For	reign
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	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code	01-00		-	en of What Cou		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)	19	b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	er, City or	Town, State, Zi	o Code)	
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ec	ne law has b ge 2 sh	ple						24a. Was autop	osv	prior to co	opsy findings avail empletion of cause	able of
		Completed						perfo 1∐ Yes	rmed? 2 Albo	death? 1 ☐ Yes	2□ No	
Vita	sician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?			l au	26. Place of Deat	h (Check only o	ne)			
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Sio	tend leath tor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of i	-i AA b	·		res 2□No					
\leq	or At fter d Direction by	ŧ	determined 200. Flace UI	etc. (Specify)	iarm, str	eet, factory, office		City or Tou	street and vn, State)	Number or Hui	al Route Number,	
	pital urs a eral l		29a. Certifier 1 Certifying Physician: To the best	et of my knowled	ao doat	b occurred at the tim	o data and place	and due to the	001100(0)	and manner as	ntate d	
	Hos 24 ho Fun etely	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	of examination a	and/or in	vestigation, in my or	pinion, death occu	rred at the time,	date and	place, and due	to the cause(s)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Me	29b. Signature and tife of certifier / /	Pidio di		29c. License	number		29d. Date	signed (Month	Day, Year)	
	->- o		> Ide Italia	120 /	110		12/01		\	¬	7 m 8	/
1	\	}	30. Name and address of person who completed cause of	death (Item 23a	(Type	Print)	THIO		fin	C of	2000	1
Ĺ	1		Mail HALVERSON	MAN	14	1)5 A	an	and (1 +	Tello	cel las	1
	Sta	te	31. Date filed (Month, Day, Year) 32. Begis	strar's Signature	À	and I	(20	th
	Registr		10 1 0 2008 Bee	we do	A						P (.	
			IAN + V									

08-00287 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rachel Chelsey Gohr Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 10, 2008 1734 hrs Medical Examiner Rachael Chelsey Gohr 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Greenbelt 228 Lastner Lane 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min Director CountryMaryland M 2X F 9/10/1973 220**-**15-9721 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No items 23a or 28a-f show ist be notified at once, Greenbelt Prince George's MD Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 228 Lastner Lane 20770 U.S.A. Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married 2 X No Yes "natural", or Specify: White If Yes, Give Year Yes 2 X No specify: Widowed Divorced à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 MD 21215-0036 Omega Uniforms Self Employed I and 2 should be filed withit Health and Mental Hygiene. marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Bannon Kathryn Grimshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Douglas Gohr, Jr, Husband 228 Lastner Lane, Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 tment of I Important: 1/17/2008 Alexandria, VA Lincoln Cemetery Donation 5 Other Specify: 22. Name and Address of Facility 21_Signature of Funeral Service Licensee 4739 Baltimore Ave. Hyattsville, MD 20781 Van ase Gasch's Funeral Home, P.A. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Promethazine intoxication complicated by alcohol use & hepatosteatos Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed Physician/Medical X UNPENDED #23a,27 attending physician or use as the burial perME, g876, 2/6/08 TT Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 🗸 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other; Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 Yes ဥ 28a. Date of Injury
[Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Yes 2 X No Pending unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) (Specify) found at home 228 Lastner Ln Greenbelt. MD Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

the Hospital or Attending Physician: hin 24 hours after death. the Within 2

> Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day Year) 32. Registrar's Sign State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Donna M Dinconti IMID

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 11, 2008

Medical

29b. Signature and title of certifier

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certific	ate of	Death				Reg. No.		
Physic	ian/	Decedent's Name (First, Mid.)	dle,Last)						2	. Date of De		Voor	3. Time of Death
ledical Exan		Dorothy Elain	e Holli	day						Month January		Year	1115 hrs
		4a. Facility Name (if not institut				4	b. City, Town, or	Location of	Death		4c. Co	ounty of Dea	ath
		3845 Ponder Drive					Edgewater				Anr	ne Arunde	el
Funera		5. Social Security Number	6. Sex	7. Age	(In yrs. last bir	thday)	If Under 1 Year	r If Under	24Hrs.	8. Date of E	irth(MM/DD	/YYYY) 9. F	Birthplace (State or
Directo		220-82-8354	1 M 2		44	•	Months Days		Min.	06/01/	1963	Fore	eign Country)Washingt
			1 M 2	A F		Yrs.				00, 01,		`	oodiniy/WaSi III igc
>		Usual Residence of Decedent		14	On City Town	or Locatio							10d. Inside City Lin
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and sho	5	Maryland Anne A	rundel		Edgewat	er							**
daryland 28a-f show	ect	10e. Street and Number					10f. Zip Code			1		of What Co	•
C le le	늅	3845 Ponder Drive					21037				United	States	5
hours after death with the Maryland harters, or items 33a or 28a-f sho	Funeral Director	11. Marital Status		as Decedent E	ver in U.S.		Decedent of His				lo- 14		erican Indian, Black,
eath	l e	1 Never Married 2 XI	Married A	med Forces?	V No	If Ye	es, specify Cuban	, Mexican,	Puerto R	ican, etc.)		White, etc.	
													hite
5-0036 led within 72 hours after Hygiene. other than "natural",	b b	15. Decedent's Education (Sp			oleted) 16a	Decedent	's Usual Occupat	tion (Give k	ind of wo	rk done	16b. Kind	d of Busines	ss/Industry
2 hou	Completed	Elementary/Secondary (0-12		llege (1-4 or 5-		during mo	st of working life	. DO NOT	use retire	d)	I		
36 nin 7	를	11	´	•		ry Cle	eaner				Drv	Clean	ing
-00 with	6	17. Father's Name (First, Middl	e Last\			19 010		18.Mother's	s Name (First, Middle	, Maiden Su		
fled of the state	Be C								,			,	
21215-0036 sold be filed within 7 Mental Hygiene. marked other than	: I o												ate Zin Code\
, MD 21215-0036 and 2 should be filed within 72 tealth and Mental Hygiene. tem 27 is marked other than "	ြို												ato, <u>-</u> .p 5555)
e, MD 1 and 2 sho Health and item 27 is		20a. Method of Disposition	irey/nusi	MIU			tion (Name of cer			Date			or Town, State
imore, MD 2 Pages 1 and 2 shoul ment of Health and M		1 X Burial 2 Crematic	on 3 Rer	noval from Stat		tory or oth		includy,		Dute	200.200	addin Only	or rom, otato
Page ent c		4 Donation 5 Other				it Memo	orial Gard	ens	01/2	2/2008	David		le, Maryland
Baltimore, permit. Pages 1 an Department of Hea Important: If ite		21. Signatur of Funeral Service				22. N	ame and Address	s of Facility	Geor	ge P. K	alas Fu	ineral 1	Home, F.A.
Per Per III		Sky 11.11	aler				73 Solomon						
Physicia	1	23a. Part I. Enter the disease,	or complication		he death. Do r								Approximate Inte
/Medica		failure. List only one caus											Between Onset Death
vamine	7	Immediate Cause (Final diseas or condition resulting in death)		(or as a conse	grence of).								+
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	a	Sequentially list conditions, if any, leading to immediate	Due to	(or as a conse	quence of):								
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	Xa	events resulting in death) Last	Due to	(or as a consec	quence of):								-1
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8760, ifficate be executed g physician and	n/Medical	IF FEMALE:	23c.	If yes, outcom	e of pregnanc	у					23d. I	Date of deliv	very
387 rtific	3 -	23b. Was decedent pregnant in past 12 months?	the 1			2 Fe	al death 3	Ectopic	pregnan	су	M	lonth	Day Year
Sox 687 leath certifit	iż.	1 Yes 2 No 9 🗸 U	nknown 4	Pregnant at t	ime of death	5 Ott	ner (Specify)				100		
Box 64 e death cert the attendir	Physicia		9	Unknown									
P.O. ss that the		Part II. Other significant cond	litions contrib	outing to death	but not resulti	ng in the u	nderlying cause	given in Pa	rt I.				to the cause of death
res th	ः। =		_							1_1	es 2 1	10 3 F	Probably 4 🗸 Unkno
Division of Vital Records, rail or Attending Physician: The law requirers after death.	ete									24a. Wa			autopsy findings avai to completion of cause
COC law law has l	글	autopsy prio performed? dea											1?
Re The	<u> </u>									1 Yes	2 No	1 🗸	Yes 2 No
tal Rectant The certificate		25. Was case referred to medical examiner? 1 Yes 2 No 26. Mace of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6											
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of ing P												occurred	
endi	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street an or Town, State)												
r Att			et, factory, office I	building, et	Number or	Rural Route Number,							
Divisior Sepital or Attend hours after death meral Director:	Certif	3 Suicide 6 Could not be determined (Specify)											
lospi hou uner		Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.											stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	edical												o the cause(s)
To the within To the	led led												(Month, Day, Year)
	≥												
		Coma MC monti, M.D O.C.M.E. January 19, 2008											
		30. Name and address of person		ted cause of de	eath (Item 23a								
2004	1	Donna M. Vincenti, I	MD Assis	tant Medic	al Examine	r 111	Penn Street	t, Baltimo	ore, MD	21201			
~~~	⊲ State	31. Date filed (Month Day, Yea	6 2000	32. egistrar	's Signature	-	-4		_				
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			For Stata Registrar	State of	of Marylar		artment <i>rtificate</i>			and M	lental		ene (	8 (	01787
4			1. Decedent's Name (First, Middle, La	st)							2. Date (		Day	Year	3. Time of Death
	Physici /Medic		Darlene	Miche:	le Hous	man					Janua		8ື້2008		5:15 P M
	Examin		4a. Fecility Name (If not institution, give	e street and nu	ımber)		4b. City,	Town, or	Location of	f Death			4c. County	of Death	
			12 Lambeth Bridge	e Court			Lut	her	/ille				Balti		
B	Funeral Director		5. Social Security Number 6. S 218 82 7113	ex □M 2 <b>2</b> F	7. Age (In yrs. 43	. last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of (Mont) Oct	h, Day, '			plece (State or Foreign intry) cyland
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	cation								10d. Inside City Limits
	anyla shov	ř													1 ☐ Yes 2 No
	Me M	Director	MD Balti 10e. Street and Number	more		Lutherv						10	g. Citizen of W	hat Car	
	with t	급	12 Lambeth Bridge	Court			10f. Zip	.093							•
	s 23	era			edent Ever in t	18 13 1	Was Deced		chanic On	ain 2 /Sn	acty Vas		United		ican Indian,
_	Itam Itam	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed F	orces?	J.3.	f Yes, spec	ify Cubai	n, Mexican	, Puerto	Rican, etc	:.)		, White	
Š	urs af	by	3 ☐ Widowed 4 € Divorced	If Yes, G Year or [	ive		1 ☐ Yes 2	ZV No	Specify:				Specify:	Wh:	ite
5	2 hou	Completed	15. Decedent's Ed			16a. Dece	dent's Usua kind of wor	I Occupa	ition			1	6b. Kind of Bu	-	
-	hin 7	ple	(Specify only highest gra		(1-4or 5+)	life.	DO NOT us	e retired,	uning mosi )	OF WORK	ny				
7	ad wit	Son	12			RFP	Speci	alis	t				Insur	ance	2
3	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  and Mental Hygiene.  and stated other than "natural", or Itams 23a or 28a-f show summaric event, in a Middeal Examination must be notified at	Be (	17. Father's Name (First, Middle, Last,									iddle, M	laiden Sumami	9)	
2	should to the Ment sements a marked umatic	ဥ	Donald F. Lentz,						Joan	Will	nelm				
0	2 sho		19a. Informant's Name/Relationship (	Type, Print)									City or Town,		
<u>≥</u>	and ealth m 27		Joan Paine/Mother		1				y Woo						MD 21043
5	ges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene.  If them 27 is marked other than, "natural", or itams 23a or 28a-f show or other traumatic evant, the Modical Examiner must be notified at		20a. Method of Disposition 1 Burial 2X Cremation 3	Removal from		Place of Dispo cemetery, crer	sition (Nam natory or o	ne of ther place	9)		Date	2	0c. Location -	City or 1	own, State
	Pages ment of I		*4 □Donation 5 □ Other (Specif	y)		rdent C					-2008		lanover		
g	permit. Pages 1 and 2 Department of Health a Important: if Item 27 It any injury or other tra once.		21. Signature of Funeral Service Licer	1500	()()M010	)44 22	. Name an	d Addres	s of Facilit	'Harı	су н.	Wit	zke's	Fami	ly FH Inc.
	20 = a		Joan och	s M	yre									ity,	MD 21043
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	caused the dea each line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac (	or respirat	ory arres	st,		Approximate Interval Between Onset and Death
9:	Physician	1	Immediate Cause (Final disease or condition	a (	CVA										minntes
	/Medical Examiner		resulting in death)		(or as a conse		1								
	Lxammer		Sequentially list conditions,		moul		vo le	ma							yrs
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):									•
	and and I-tran	Examin	that initiated events resulting in death) Last	C	(or as a conse	quence of):									
Š	cate be executed hysician and the burial-transit			500 10	(01 43 4 001130	quence ory.									
0	physi the t	dical		_ d											
<b>∀</b>	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If ves. ou	itcome of pregr	ancv							23d. Date	of deli	(AD)
2	that the death cer ed by the attendir detached for use	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	aldeath 3□	Ectopic pro						Mor		Day Year
5	the d	ysle	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkr		304.11	200101 (301	OU!! y /							
Ĺ	that the ed by detac		Part II. Other significent conditions of	contributing to d	death but not re	sulting in the u	nderlying ca	ause give	n in Part I.		23e.	Did toba	acco use conir	bute to	the cause of death?
2	w requires that s been signed t should be det	d by										1 Yes	s 2 □ No	3 🗀 Pro	bably 4 Unknown
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ני ב	he lar	ш										autopsy perform	ed? d	eath?	opsy findings available ompletion of cause of
0	ician: The la certificate has rector, page 2	e Cc	25. Was case referred to medical						00 81		101			☐ Yes	2 <b>X</b> No
>	Physician: r this certific ral director,	8	examiner?	Hospital:	Inpatient 2	] ER/Outpatier	it 3□ DO	Othe	Ar.		me 5		nce 6 Othe	r (Spec	iful
5	Phys ar this aral dis	ı; To	27. Manner of Death		of Injury oth, Day Year)	28b. Time of		8c. Injury	at				w injury occurre		(y)
5	th. : Afte	to	1X Natural 5 ☐ Pending 2 ☐ Accident investigation		nth, Day Year)	Injury	М	Work	:? Yes 2 □ I	No					
2	Atter r dea ector by the	Hice	3 ☐ Suicide 6 ☐ Could not b	289. Plac	e of Injury - At I	nome, farm, str	eet, factory	, office			28f. Locat	ion (Stre	eet and Number	or Au	ral Route Number,
5	al or	Certification;	4 Homicide	Dulid	ling, etc. (Spec	iry)					City	ir i dwii,	State)		
	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (	29a. Certifier 1 X Certifying Ph (Check only one) 2 Medicel Exer	niner: On the b											
	o thi	Me	29b. Signature and title of certifier				29c	. License	number			29	d. Date signed	(Month	, Day, Year)
	F > F 0		I Sett	the m	2		The second second	DL	131	) )			January	9.	2008
\	~		30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type.	Print)			_					<del>-</del>
0			Lise Satterts	eld	515 F	وم مدا س مادار	· ·	Ave	- TX	מוצ מתו	n M	0 0	11286		
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Sign	ature		-1-			- / -				
	Registr		JAN 10	2008	College	13. L	23456	,							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2 No

Maryland

White

Horner

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 □ No

Month

1 ☐ Yes

29d. Date signed (Month, Day, Year)

JANUARY

Mon the

Year

10:50 P M

Division or Vital Records, P.O. Box 68760 Physician/Medical 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SMITH

1 0 2008

516 TRAIL AVE: FREDERICK 32. Registrar's Signature

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \\ \FDICAL DIRECTOR, I-OFFICE of FREDERICK

29c. License number

D10587

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Physician 0550 M Dennis J. Hitch, Sr. 07, Lancary 2008 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Regional Medical Center Salisburg Vicanica eninswa 8. Date of Birth (Month, Day, Year) 12-16-1939 If Under 1 Year | If Under 9. Birthplace (State or Foreign Country) Laurel, Delaware Social Security Number **Funeral** Months Days Hours 221-24-0501 **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No DE Laurel Sussex Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19956 USA 30207 Discount Land Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 💥 No Specify. Specify: White þ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 General Manager Grocery/ Food d 2 should be filed w th and Mental Hygiei 7 Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Brittingham Norman Hitch ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If Item 27 Is n any injury or other traun 30029 Stoney Brooke Drive Salisbury, Md. 19904 (daughter) Terri Evans 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1-10-2008 Laurel, Delaware Odd Fellows Cem. 4 □ Donation 5 □ Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility 700 West St. Hannigan, Short, Disharoon

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. 19956 Laurel, De. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 ATTA Craw day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-tran Due to (or as a consequence of): attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of page 2 death? certificate cel Carc 1∐ Yes 2 No rana funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records.

Box 68760.

P.0.

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, State JAN Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

Sil 15 MO 32/Registrar's Signature Year) 14 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Regional medical Center

29d. Date signed (Month, Day, Year) 80

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Ewaynia Cleothia		ggins St; - For State Registrar	ate of Maryland		nent of l cate of l		l Mental H		Reg. No.	200	8 0179	
Physicia	n/	Decedent's Name (First, Middl	e,Last)					2. Date of Dea	ath Day	Year	3. Time of Death	
Medical Examin		Ewaynia 4a. Facility Name (if not institutio	Cleothia H	iggins	- I 4h	. City, Town, or I	section of Death	January 1	15, 2008	ounty of Death	0331 hrs	
<b>(</b>		Southern Maryland Ho				Clinton	ocation of Death		L L	nce George		
Funeral	٦	5. Social Security Number	6. Sex 7. Age	e (In yrs. last b	irthday)	If Under 1 Year Months Days		_	rth (MM/DD/	YYYY) 9. Birt Foreig	thplace (State or	
Director		363-84-3580	1 M 2X F	31	Yrs.	Days	Flours Will	Sept.2	0, 19	76 Det	Trot, Mi.	
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City, Tov	vn or Location	1					10d. Inside City Limits	
and show nce.	5	Maryland Prince	e Georges	Upp	er Mar	lboro					1 X Yes 2 No	
Maryl r 28a-1	rect	10e. Street and Number	1 041-			10f. Zip Code	,	10g. Citizen of What Country?  United States				
1 45   ath Maryland and 32a or 28a-f show any ist be notified at once.	Funeral Director	4523 Bishophil.	12. Was Decedent	Ever in U.S.	13 Was	20772 Decedent of Hisp		necify Yes or N			ates	
Jeath w	nnel	1 X Never Married 2 Ma	arried Armed Forces?		If Yes	s, specify Cuban,	Mexican, Puerto	Rican, etc.)		White, etc.	_	
after crall, or			orced If Yes, Give Year or Dates:			es 2 X No				ecify:		
2 hours	ţę.	15. Decedent's Education (Specific Elementary/Secondary (0-12)	College (1-4 or 5		a. Decedent's during mos	Usual Occupati t of working life.	on (Give kind of DO NOT use ret	work done ired)	16b. Kind	d of Business/I	Industry	
036 ithin 7.	Completed by	12	2		Unemp	loyed				N/A		
		17. Father's Name (First, Middle,	Last)	<u> </u>		Unk 1	8.Mother's Nam	e (First, Middle, Higgins		rname)		
212 212 uld be Mental marke	To Be	19a. Informant's Name/Relations	hip (Type, Print )	- 1	19b. Mailing A	Address (Street				or Town, State	e, Zip Code)	
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ti. Page trant	ļ	4 Donation 5 Other Sp	pecify:		21/2008	Redi	ora tov	wnship,Mich.				
Bal permi Depar Impo injur	Į	21. Signature of Funeral Service	war 2 MOI	085	22. Na	me and Address Alexande 5538 Mar	Tboro P	Pre/For	ėstvi	11e. M	d. 20747	
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30x death c ne atten I for us	ysic	1 Yes 2 No 9 🗸 Unk		time of death	5 Othe	er (Specify)						
D. D. hat the ed by the etached	by Ph	Part II. Other significant condit	ions contributing to death	but not resul	ting in the un	derlying cause g	iven in Part I.				the cause of death?	
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tal Rection: The certificate	ဦ -	25. Was case referred to medical		-		26 Place	of Death (Check	1 <b>✓</b> Yes	2 No	1 🗸 Y	es 2 No	
Vital ysician his cert directo	o Be	examiner? 1 ✓ Yes 2 No	Heavital: -	nt 2 🗸 ER	/Outpatient		Othor:	ng Home 5	Residence	e 6 Othe	r:	
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be rs after death.  al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burn	h	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 28 ear)	b. Time of Inju	· 1	y at Work?	28d. Describe	how injury	occurred		
Sion Vittend death. ector:	lgi lgi	Feric	stigation		f		es 2 No	006 1	/Ct===t ==d	Nombre of D	mal Davida Numb as City	
Division of Vital Rec pital or Attending Physician: The I ours after death. reral Director: After this certificate filled in by the funeral director, page	Certification:		d not be (Specify)	jury - At nome	, iaim, street,	factory, office be	uliding, etc.	or Town,		Number of Ro	ural Route Number, City	
8 E E >										manner as stat	ted.	
To the Hos within 24 h To the Fur completely	Medical		and manner stated.	mination and/o	or investigatio			at the time, date				
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	-	30. Name and address of person			a)					,, 230		
R		Donna M. Vincenti, Mi	·	,		Penn Street,	Baltimore, N	/ID 21201				
Sta Registr	ite	JAN 2 2 2008	32. Registra	r's Signature	K)							
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DHMH 17 Rev 1/2001 OCME 2006

Physici Exam	an/	1- For State Registrar  1. Decedent's Name (First, Middle,Last		-	e of Death		2. Date of De Month	Day	200 Year	3. Time of Death 1313 hrs
LAdiii	illei	4a. Facility Name (if not institution, give Ft. Washington Hospital			4b. City, Town, o		January	4c.	S County of Deat rince Georg	_ <b>I</b> th
uneral irector		5. Social Security Number 6. Sec.		yrs. last birthd		ar If Under 24	Hrs. 8. Date of B	irth (MM/6	00/YYYY) 9. Bi	orthplace (State or ign North  ountry Carolina
iow any e.		10a. State 10b. County  Maryland Prince		C11	Location				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits 1 X Yes 2 No
r 28a-f sh ied at onc	Director	10e. Street and Number			10f. Zip Code	) F		-	en of What Cou	-
giene. her than "natural", or items 23a or 28a-f show . Medical Examiner must be notified at once.	Funeral D	12816 Piscataway  11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Ever Armed Forces? US	rin U.S. 1	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin?			ed Stat 14. Race - Ame White, etc.	rican Indian, Black,
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' injury or other traumatic event, the Medical	Be Cor	17. Father's Name (First, Middle, Last)  Lancelot Hasse	11, Sr.	I		18.Mother's Na	ame (First, Middle <b>Lee (</b>			
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After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.  X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. 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fiber death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  JUNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigatic 3 Suicide 6 Could not to determined 4 Homicide  29a. Certifier 1 Certifying Physiciane) 2 Medical Examiner:	Cardim valv words a conseque to (or as a conseque Due Due Due Due Due Due Due Due Due D	nce of):  nce of):  nce of):  nce of):  erME, g87  pregnancy  of death 5  ER/Out  28b. Til	ntricular hy, latation  6, 2/1/08 TT  Fetal death 3 Other (Specify)  In the underlying cause  26.Plate the underlying cause  26.Plate the underlying cause  26.Plate the underlying cause  3 DOA  The of Injury 28c. In, 1  1 cocurred at the time, estigation, in my opinion	Ectopic pre	and right  23e. Did 1 Y 24a. Wa aut 1 Y Yes eck only one)  28d. Describe 28f. Location or Town, and due to the ca	tobacco uses 2 No. Resider a how injution (Street and State) use(s) and e and place	Date of deliver Month  Use contribute to No. 3 Proceed Proceed Proceed Proceed Proceed Proceed Proceed Proceed Proceed Proceed Proceed Proceed Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Procedure Pro	Approximate Interval Between Onset and Death  Between Onset and Death  Pary Pary  O the cause of death?  Obably 4 Unknown autopsy findings availably completion of cause of Yes 2 No  Per:  Rural Route Number, City ated.  Atthe cause(s)
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DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James William Johnson 11:16 P Jan 6, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 2 M 2 □ F **Director** 212-44-1216 88 Oct 25, 1919 D.C Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County notified at 1 ☐ Yes 2 No Director Prince Georges Capital Heights MD 23a or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 20743 IIS A 160 Diamler Court death v Funeral 14 Race - American Indian items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 `No If Yes, Give 0 1 ☐ Yes 2 No Specify. Specify: þ Black 3⊠Widowed 4 Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Construction 6 Laborer permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important; If item 27 is marked other if any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Emerson Walter Harrison Johnson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 2031 Upper Marlboro, MD 20773 Frank S. Taylor /Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/08 Chesapeake Beach, MD **Ernestine Jones Cemetery** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed Due to (or as a consequence of): attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year Yes 4☐Pregnant at time of death 5 Other (specify) 2 No the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed' certificate 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760. P.0. Records, Division or Vital

Baltimore, Maryland 21215-0036

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral After t

State Registrar

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Livile Rd A312 Bowle My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Ronnie Bennett .Tones January 10 2008 7:52 p. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1123 Keys Road Fishing Creek Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F 68 April 15, 1939 Maryland Director 215-38-1839 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County , or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Dorchester Fishing Creek Director death with the 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1123 Keys Road 21634 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: þ white 3 Widowed 4 Divorced Year or Dates: natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) the d owner/operator seafood s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 Is marked other th 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson B. Jones Olive Creighton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any injury or other trau Betty A. Jones 1123 Keys Road, Fishing Creek, MD 21634 wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 1/15/08 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. k. B 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Town Chanic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. disorder 2 No 3 Probably 4 Unknown Completed fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
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 Natural Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760. Division or Vital Records, To the Hospital or

n 24 hours after death.

Pe Funeral Director: A pletely filled in by the fil

within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061877 ZÓ08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Widmaier, M.D. 503 Byrn St., Cambridge, MD

State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year) 32. Regi ar's Signature JAN 14 2008



21613

**Physician** /Medical Examiner The law requires that the death certificate be executed and burial-trai Division or Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

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Completed

Be

3□ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

**Physician** 

/Medical

Examiner

Directo

Funeral

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**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show

Pages 1 and 2 should

or other traumatic

permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau

Maryland 21215-0036

Baltimore,

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

attending physician as the use for the detached should be has page 2 certificate

To the Hospitai or Attending Physician: death. after death Director:

completely filled in by the funeral director,

Certification: To within 24 hours a

To the Funeral I Medical

State Registrar

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Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PO BOX 1733 STUBBURY UD 21802

31 Date filed (Month.

Physician	
/Medical	
Examiner	

4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 M 2X F 12/27/1922 Director 154-18-4284 85 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at Director MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 2815 Patuxent Court 20678 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examinar must in Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No <u>≽</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Be Emil McCall Clara Swartz ပ 19a. Informant's Name/Relationship (Type. Print) Robert J. Kuntz - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute /Medical Due to (or as a consequence of): **Examiner** CABG CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): chronic 97-8191 use as the burial-trai Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, signed by the attending physician Uxosepsis IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes | 2 | No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide and manner stated. 29b. Signature and title of certifier 29c. License number Shal D 50290 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fred Show 110, 40sp 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Certificate of Death 2. Date of Death 01/09/2008 04:55a M 4c. County of Death Calvert Birthplace (State or Foreign Country) PA 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2815 Patuxent Court Prince Frederick, MD 20678 20c. Location - City or Town, State Arlington National Cem 01/16/2008 Arlington, VA 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings MD 20736 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | 1 hknown 24b. Were autopsy findings available prior to completion of cause of death? 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 1-9-08 MD 20678

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month MARGARET STRUSHOLM KING 208 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury, MD Wicomico Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🗓 F 043 24 2072 Director 11/16/1930 Connecticut Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐Yes 2☐No Director VA Accomack Greenbackville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3476 Navigator Drive 23356 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√DNo Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 72 in and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 12 homemaker 17. Father's Name (First, Middle, Last) Be Campbell Strusholm Margaret Lindberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau P.O. Box MN4, 3476 Navigator Dr., Greenbackville, Charles Robert King, Sr./spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crem. 1/10/2008 Salisbury, MD 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Much Holloway Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1103 Linden Ave., Pecemoke City, Md 21851

Approximately 1204

Approx Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FAILURE MULTIPLE ORGAN /Medical Due to (or as a consequence of): Examiner BDOMINAL SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ERFORATED physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 No after death.

Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after

To the Funeral Dire

completely filled in b 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aucho 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 1 2008

BA 6

Margard King 043+24-207

32. Registrar's Signature

E. CARROW ST. SALISBURY

**Physician** /Medical Examiner

Department of H
Important: If ite
any injury or ot
once.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be ည

**Funeral** 

Director

the Maryland a or 28a-f show the notified at

Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n

Baltimore, Maryland 21215-0036

Examiner burial-transit physician Physician/Medical as ð page 2 s funeral director. Be Certification: To

The law requires that the death certificate be executed certificate Hospital or Attending Physician: this After after death completely filled in by within 24 hours a To the Funeral C the

Division or Vital Records, P.O. Box 68760.

attending a ed by the signed I Completed

25. Was case referred to medical examiner? 1 🔲 Yes

29a. Certifier Medical

State Registrar

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

28a. Date of Injury (Month, Day Year)

and manner stated.

9□ Unknown

Injury

3 □Ectopic pregnancy 5 ☐ Other (specify)

2 No 1 ☐ Yes 24a. Was an

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

Vear

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

January 9, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Merly K. Vemury M.D. 9801 Georgia Avenue - #227, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

20 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

2008

5 Pending investigation

6 Could not be determined



DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Karen Lillian January Kelly 20්රී්ර් 4:12 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Apr. 19, 1944 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Davs Hours Min Country) 560-60-2344 63 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits MD Frederick Frederick 1 ☐ Yes 2 🛣 No 10e. Street and Number 4219 Lime Kiln Dr. 10f. Zip Code 10g. Citizen of What Country? 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Schneider Gladys Scofield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Kelly (Husband) 4219 Lime Kiln Dr., Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory1/7/08 | Smithsburg, MD 4 □ Denation 5 □ Other (Specify) 21. Signaturi 22. Name and Address of Eacility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications the gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pheumonia Due to (or as a consequence of) Blee GI Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): i'rr hosus Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2☑No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner burial-trai attending physician Division or Vital Records, P.O. Box 6876 as for 1 þ signed t

Examiner has page 2 certificate

Physician

/Medical

Examiner

**Funeral** 

Director

show at

"natural", or items 23a or 28a-f sl edical Examiner must be notified

72 hours after

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Physician/Medical Completed funeral director, Be ဥ Medical Certification:

the Hospital or Attending Physician; To the Funeral Director: completely filled in by the hours

24

State Registrar

29b. Signature and title of certifier

6 Could not be determined

MD

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mydusan 31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

JAN 1 0 2008

Frederick 32. Registrar's Signature Memorial

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Deborah Lynn Kummer 2008 7:45 January 8, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 629 Dover St. Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 1 □ M 2 👿 F 213-60-5708 Director 56 Maryland 12/24/1951 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Funeral Director Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 629 Dover St. 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No thmore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. white Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 work adjustment trainer Lower Shore Enterprises 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William G. Neary Clara Agnes Barnes ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Kummer/husband 629 Dover St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/08 4 □Donation 5 □ Other (Specify) Salisbury Crematory Salisbury, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home Professional Association Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Physician Metastat disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9☐ Unknown cate has been signed by , page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No certificate 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 Tyes 2 No 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a, Certifier LZ certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D29283 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 E. Carroll St., Salisbury, MD 21801 J. Taylor 31. Date filed (Month, Day, Year) Registrar's Signature State 11 2008 JAN Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		I- For State Registrar		Cert	tificate of	Death		, ,	Reg.		UU	0 01000
Physicia	n/	1. Decedent's Name (First, Mid						2.	Date of Death Month	ay Yea		3. Time of Death
ledical Examin	ier		Patrick	•		h City Town or	l continu ni		January 20,	2008		0550 hrs
		4a. Facility Name (if not institut Washington County		nber)		b. City, Town, or Hagerstown		Death		4c. County of Washing		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	_					nplace (State or
Director	Į	216-96-4125	1 X M 2 F	43	Yrs.	Months Days	Hours	Min.	12-13-1	L964	Cou	Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	v	10c. City.	Town or Locati	on						10d. Inside City Limits
	ᆡ		shington	1007 01197	Hager							1 Yes 2 X No
Sa-f sl	ᅙ	10e. Street and Number		·		10f. Zip Code			10g	. Citizen of Wh	at Coun	try?
the Marylan 13a or 28a-f sl	Director	19612 Cool Ho	llow Drive			217	40			United	1 St	ates
with ms 23	ala	11. Marital Status		edent Ever in U.S		s Decedent of His						can Indian, Black,
or ite	Funeral	1 Never Married 2	1 Yes	2 X No		es, specify Cuban		Риепо кі	can, etc.)	vvnite	e, etc.	
s after	ক্র	Widowed 4 X D  15. Decedent's Education (Sp	or Dates:			Yes 2 X No		in d of	1 14	Specify:	Whi	
2 hour	Completed	Elementary/Secondary (0-12				t's Usual Occupat ost of working life.				6b. Kind of Bu	siness/ii	ndustry
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5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middl							irst, Middle, Ma	iden Surname	)	
2121 suld be fi Mental   marked c event,	8	Edward Joseph	,						y Prout			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relation Rosemary Lyo	ns / Mother	c	1 2501	Colerid	t and Num oe Dr	ber or Ru≀ '1VA	al Route Numbe -Unit 1	er, City or Tow C. Fred	n, State, 1eri	Ck MD
and 2 fealth item 2 traum	- 1	20a. Method of Disposition		20b. P	lace of Dispos	ition (Name of cer	metery,	<u> </u>	Date	20c. Location		
Baltimore, Department of He Important: Tite		1 X Burial 2 Cremati		AII State	rematory or oth	^{ner place)} 'et Cemet	oru	Janu 24,	ary	Frede	rick	, Maryland
Baltin permit. P Departme Importan injury or	1	4 Donation 5 Other 21. Signature of Funeral Service		->		lame and Address eeney &		24,	2006 <u> </u>			, , , , , , , , , , , , , , , , , , ,
E P P		CAC	100	M0143	$\frac{1}{1}$	06 East	Churc	h St	.a. run reet, F	erai Ho rederio	one ck, ]	MD 21701
Physician		23a. Part I. Enter the disease, failure. List only one caus		used the death.	Do not enter th	ne mode of dying,	such as ca	ardiac or r	espiratory arres	t, shock, or he	art	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease				and benzod	iazepi	ne int	oxication	1		Death
And the second		or condition resulting in death)	Due to (or as a	consequence of	):							
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760 icate b physi	/Me	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, o	outcome of pregr						23d. Date of	delivery	,
Box 68: death certifi the attending ed for use as t	cian	past 12 months?	1 Live bi	irth ant at time of dea		tal death 3 her (Specify)	Ectopic	pregnanc	Эy	Month	[	Day Year
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Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director.	Be (	25. Was case referred to media examiner?					of Death					
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Division To the Hospital or Attend Within 24 hours after death. To the Funcral Director: completely filled in by the 1	Medical		xaminer: On the basis of and manner st	of examination artated.	nd/or investiga			curred at t	he time, date a	nd place, and	due to th	e cause(s)
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	Į	Joish	ate	y ru	W	O.C.	IVI. <b>∟</b> .			January 2	1, 200	5
		30. Name and address of personal Tasha Greenberg M		~		Penn Street,	Raltimo	re MO	21201			
The Cu	ate	31. Date filed (Month, Day, Yea		gistrar's Signatu		emi street,	שמונוווט	, IVID				
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Daniel Bain Love		- For State Registrar	Sta	ate of Maryland		tment of ificate of		nd Ment		Reg. No.	20	08 01	180	
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Baltimore, MD 21215-0036 UKS permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	429 Wil	lis St	reet				21613		3	USA			
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	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier													
To the within 2 To the complet	Med	29b. Signature and		and manner stated.	-			nse number				Month, Day, Year)		
	-	A	12 (1)	11 200				.M.E.			ry 18, 20			
	-	30. Name and addr	ess of person	who completed cause of	death (Item :	23a)								
		Pamela E. S			,		Penn Stre	et, Baltim	ore, MD 21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yea Physician 2018 ARDARA Tanua /Medical 4b. City, Town, or Location of Death 4c. County of Peath acility Name (If not institution, give street and numbe Examiner 504564KG 100mico KegiaNAL If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Hours Months Days Min 1 □ M 2 🗶 F 224-50-0036 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director ICOMICO 10g. Citizen of What Country? 10e. Street and Number 23a or death v Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race -American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify <u>م</u> 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 40MEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type, Pent) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOORE injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee in BENNIE Smith F.H. 23a. Part1. First the Assistance, or heart faile.
Immediate Cause (Final disease or condition resulting in death) sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ilure. List only one cause on each line. -ticemia **Physician** Candida /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 TYes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No mellid 24a. Was an autopsy performed arter disease corgrand 3 or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A death. 2 Accident 6 ☐Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 🥄 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and place and 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennsula Regional Medical Center Salisbury Silvia mo Jr

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Allen Layton Steven 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egional Medical Center 1) ICOMICE If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, **Funeral** Months Min 1**X** M 2 □ F 51 220-68-8526 Director 1/19/1956 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Salisbury Wicomico Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 1937 Pineway Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after ☐Yes 2 🔀 No Yes, Give 'ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 medicine distributor Perdue Hatchery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fi f Health and Mental H tem 27 is marked otl Be Elma Loretta Elliott Charles Edward Layton ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau 1937 Pineway, Salisbury, MD 21804 Elma L. Layton/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 1/14/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park
22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 Structure numman Monic le mean /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> cate has been sig ; page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3 **40**0A Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after oeaun.

To the Funeral Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A 24 hours after 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

30. Name and address of person who RUDIVEY

29b. Signature and title of certifier

Ci. Wennich M.D

29c. Liçense number

29d. Date signed (Month, Day, Year) VAN. 11, 2008

ompleted cause of death (Item 23a) (Type, Print)

1346 S. DIVISION ST.

SALISBURY

Year) distrar's Signature JAN

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits									
Maryland Anne Arundel Annapolis		1 ☐ Yes 2 No									
10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?									
130 Hearne Road, Apt. 911 21401	U	nited States									
Maryland Anne Arundel Annapolis    Maryland Anne Arundel Annapolis   10f. Zip Code   130 Hearne Road, Apt. 911   21401   11. Marital Status   1   Never Married 2   Married   1   Never Married 2   Never Married 3   Never Married 3   Never Married 3   Never Married 4   Never Married 4   Never Married 5   Never Ma	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.									
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Carl D. McCoy, Jr.  19a, Informant's Name/Relationship (Type, Print)  19b, Mailing Address (Street and Number or Ru	t E. McFa										
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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or Town, State									
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21. Signature of Fondal Service Licensee 22. Name and Address of Facility Ge	orge P. K	alas Funeral Home									
2775 BOTOMOTIS ISIAN											
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.											
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	ath (Check only one	)									
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27. Manner of Death  28c. Injury at Work?  1 Natural 5 Pending (Month, Day Year)  28c. Injury at Work?  1 Yes 2 No	Zou. Describe nov	rinjury occurred									
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25. Was case referred to medical examiner?  1   Yes   2   No   No   No   No   No   No   No											
29b. Signature and title of certifler  29c. License number  20c. License number  20c. License number	-	d. Date signed (Month, Day, Year)									
29b. Signature and title of certifier  Doo327  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  To look Done & M. V. 94 70 Approx Dollie Rd.	-										
29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License nu	-										

Re DHMH 17 B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2008 Januar /Medical 4b. Çity, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner WOSTINSTON Mastlina asso 1000 CD 8. Date of Birth (Month, Day, Year)
Jan. 31,1920 Social Security Number 7. Age (In yrs. last birthday) 9. Birthe ace (State or Foreign **Funeral** Days Months 1 □ M 2 🕅 F 207-20-0340 87 Yrs Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Williamsport 1 □Yes 2x No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21795 16505 Virginia Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No white Š Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dr. Samuel Newman Ida Greenberg P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold V. Macht - son 13519 Donnybrook Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If Its any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 13, Greenhill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Danville, Pennsylvania 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 resulting in death) naequence, of): /Medical Due to (or as a c Examiner "ROTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> Pesusci Tose 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed Alzhames Demoutiv 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has trector, page 2 s autopsy perform death? 1 ☐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural (Month, Day Year) 5 Pending investigation ours after death.

neral Director: Af
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours at To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-12 istrar's Signature 31. Date filed (Month, Day, Year) 32. R State 14 2008 Registrar

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

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			For State Registrar	State of Ma	ryland		artment of H <i>rtificate of L</i>			giene Reg. No.	008	01807
ï	Physici	an	1. Decedent's Name (First, Middle, Li	ast)				_	2. Date of De		Year	3. Time of Death
	/Medic	cal	Helena Perenya  4a. Facility Name (If not institution, gi				4h City Town or	Location of Death	Januar	y 7, 2	nty of Death	3:44 A M
į	Examin	ier "	12824 Clarksburg		d #20	)5	Clarksbu				gomery	
	Funeral		Social Security Number 6.	-	(In yrs. las		If Under 1 Year Months Days	_	8. Date of Bir (Month, Da	th av. Year)	9. Birthpl	lace (State or Foreign
Į,	Director		577-94-5608 Usual Residence of Decedent	TE IVI ZENT	94	Yrs.			May 29	, 1913	Spain	i'
	yland how at		10a. State 10b. County		10c. City, T	own or Lo	ocation				10	Od. Inside City Limits
	e Mar Ba-f sl	ctor	MD Montgome	ery	Clark	sbur	g					1 ☐ Yes 2 X No
	with the	Dir	10e. Street and Number	Carrage De-	1 1/20 E	=	10f. Zip Code				of What Count	ry?
	ns 23	Funeral Director	12824 Clarksburg	12. Was Decedent E			20871 Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp		Spain - 14.F	Race - America	an Indian,
0	72 hours after death with the Maryland natural", or Items 23a or 28a-f show iteal Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	О		If Yes, specify Cuba  1	Specify:			Black, White, e	
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	be file	Be	17. Father's Name (First, Middle, Las Alfredo Perenya	<i>t</i> )				18. Mother's Name Elena Par	•	, Maiden Suri	name)	
Ž	2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the Mark	은	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street a			er. City or To	wn. State Zin	Code)
MG.	and 2 saith ar		Maria Sprehn/gran	nddaughter			Day Aven					
1) 2)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 [	Removal from State			osition (Name of matory or other place		Date	20c. Locatio	on - City or To	wn, State
	it. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Spec	ify)	Chesa		e Cremato				ille, N	
ם ח	permit. Departr Importa any Inji	IJ	21. Signature of Funeral Service Lice	Hollet			2. Name and Addres					
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	MO125	Do not ent	everly L.	g, such as cardiac	rresp atory a	rrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of)		1	1	m	D43	4
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C					The		1 01	/
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20/00,	eath certificate be executed attending physician and for use as the bunal-transit	edical		d			M,				'	
5	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p						23d.	Date of deliver	rv
	e death	Physician/M	in the past 12 months? 1 ☐ Yes 2 <b>K</b> No	1 □Live birth 2 4 □ Pregnant at 1 9 □ Unknown			□Ectopic pregnancy □ Other (specify)					Day Year
	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions		h mak unavikius		-4-4-4-4	on to Book (	00- Did			
Ď,	signe d be d	d by	Faith. Other significant conditions	contributing to death bu	i noi resulli	ig iii tile ui	ndenying cause give	en in Part I.	1			e cause of death? ably 4 □Unknown
5	w required should	Completed							24a. Was			osy findings available
ב	The la	omp							auto	psy ormed?		npletion of cause of
	hysician: The la his certificate ha I director, page 2	BeC	25. Was case referred to medical examiner?					26. Place of Deat				2 110
5	Physic this c	ျှ	1X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury				4 □ Nursing Ho				)
5	ding h. After funer	tion	1 □ Natural 5 □ Pending 2 ★Accident investigatio	(Month, Day	Year)	b. Time of Injury unk)	Work	rat :? Yes 2 <b>X</b> 1No	28d. Describe	now injury occ	currea	
2	Atter	Certification:	3 Suicide 6 Could not be determined	De 290 Place of initial	y - At home	-				Street and Nu	mber or Ryral	Route Number,
2	ital or rs afte ral Dir	Cert		at home					12824 C	Tarksb	urg Sq.	Rd. #205
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death certif thin 24 hours after death after this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 ▲ Certifying P  (Check only one) 2 ■ Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination	dge, death and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	date and place	manner as sta ce, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sig	ned (Month, L	Day, Year)
_			> U. Seid	man Y	NP		D3780	1		Januar	y 7, 20	80(
(j	o ao		30. Name and address of person who Aimee Seidman, M.				_{Print)} e Rd. Sui	te 300 R	ockvill	e, MD	20850	
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 0	2008 32. Registrat	's Signature	* *	barle					

DHMH 17 Rev 1/2001

2. Date of Death 1. Decedent's Name (First, Middle, Last) January 9 Day 2008 Year Physician 8:55 A M William Moorehead /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 X M 2 □ F May 27, 1929 Maryland Director 213-24-6563 78 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼No Directo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 2911 Beaver Lake Court or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1946-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White by Specify. 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within h and Mental Hygiene. 7 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental John William Moorehead Margaret Reeves ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 2911 Beaver Lake Court Ellicott City, MD 21042 Heidi Martin/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Iter
any injury or oth 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Chesapeake Crematory | 01/10/08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner-Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The sensuspendent in roll of leading Examiner or Attending Physician: The law requires that the death certificate be executed Pulmonary Fibrosis Due to (or as a consequence of) Completed by Physician/Medical Rheumatoid Arthritis IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. **Other** s**ignificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation, depression 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed' certificate 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 9 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Kanumuru, M.D.7300 Van Dusen Rd. Laurel, MD 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 11 2008 **Physician** ZACHARIAH **JANUARY** 2:50P M HARRY MUSGROVE, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LORIEN of MOUNT AIRY CARROLL MOUNT AIRY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov. 12 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 M M 2 □ F Director 220-09-5981 88 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location sa or 28a-f show t be notified at 10d. Inside City Limits 10b. County Carroll Md. Mount Airv 1 TYes 2 No Director death with the 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? ns 23a c 909 Promenade Lane 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status n"natural", or items edical Examiner m Black, White, etc. filed within 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ Specify: 3™ Widowed 4 □ Divorced WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier Postal Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Hines Zachariah Musgrove, Sr. Emmalee ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 6503 Carrie Lynn Court, Mt. Airy, Md. permit. Pages 1 and Department of Health Important; if Item 27 any Injury or other tr Arlene F. Robey / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 1/18/08 Sunshine, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia Bilateral 4 Days /Medical Due to (or as a consequence of) Examiner Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Chronic Obstructive Pulmonary Disease Years burial-tran Due to (or as a consequence of). Box 68760, Physician/Medical Years Atrial Fibrillation the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 pe Depression, Anemia 1 🗌 Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia, Failure to Thrive 24a. Was an page 2 s autopsy performed? res 2.2 No Pacemaker, Coronary Artery Disease 1☐ Yes Division or Vital funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident in 24 hour.

the Funeral Directory filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2 and manner stated. 29b. Signature and title of tertifier 29c. License number 29d. Date signed (Month, Day, Year) D 54749 January 11, 2008 30. Name and address of person who completed cause of de tem 23a) (Type, Print) 10+1 801 Toll House Ave., D-1, Allen Reilly, M.D. Frederick, Md. 21701

State

Registrar

31. Date filed (Month, Day, Year)

32. Registre's Signature

2008

JAN 1 4

Division or Vital Records, P.O. Box 68760

State Registrar

Date filed (Month, Day,

2008

DHMH 17 Rev 1/2001

Ave, Dt, Frederick, md 2170/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month . Decedent's Name (First, Middle, Last) Physician 8:15 PM William Russell Murphey Jr. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner castal Hospice 13bur u Wicomic at 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 🔀 M 2 🗆 F Davs 214-50-1871 59 Director 5/17/1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 cab driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Howard William Russell Murphey Sr. ပ 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27983 Malden Ct., Salisbury, MD 21801 Krah Plunkert/friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 1/14/08 Salisbury, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd. Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MRTASTATIC LUNG CARCINOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA ္ရ 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending within 24 hours after death To the Funeral Director:

6 HUMM WARES 31. Date filed (Month, Day, Year) Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

JAN 14 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O DOX 1733 SALISBURY UD 21202 HOSPICIZ COASTAL

and manner stated

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0005 2410

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lonnie 1920 M Mercei 08 2002 OI /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Burn John Hopkins 5. Social Security Number Baltimore Date of Birth (Month, Day, Year) 7-23-53 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Hours 54 222-38-3625 DE Director Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director WORCESTER ISHOPVIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9905 218 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: USMC 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ERCHANDISING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ERCER ပ ABEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Ro BISHOPVILLE WIFE VALERIE MD 21813 - HOTEL 20b. Place of Disposition (Name of Cemetery) crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/08 BISHOPVILLE 22. Name and Address of Facility BENNIE 21. Si n ☐ Function Service Licenses Smith FIH SACISBURY, 7-W. ISABELLA 23a. Part1. Extende dis shock, or heart fails ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e. List only one cause on each line. immediate Cause (Find disease or condition resulting in death) Thermal **Physician** epsis complication 2 weeks /Medical Examiner Respiratory weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Respiratory

Due to (or as a consequence of): Fally a weeks Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical Failure week IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown WED 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 

No 24a. Was an certificate has autopsy performed? 2 No 25. Was case referred to medical examiner?
Yes 2□ No Be 26. Place of Death Check onl one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? : After 1 1 Natural 5 Pending investigation Injury 12/19/07 1 🗌 Yes Accident unknoun M Burning Brish with Gascline 281. Location Street and Number or Rural Route Number, Oity or John, State) 24 hours after death e Funeral Director; 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide Hetel Read Bishopville Mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the

State Registrar 29b. Signature and title of certifier

Alsouh assess

within 7

2

ND

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1_ For State	State of Ma		artment of He	ealth and Mer		7 11 11	8 01813
			Registrar  1. Decedent's Name (First, Middle, I	( act)	Ce	I IIII Cale OI L		Reg. Date of Death	No.	3. Time of Death
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	/Medic		4a. Facility Name (If not institution, g	nive street and number)	10166	4b. City, Town, or		anuary	4c. County of [	
r	Examin	ier	Homewood at Cra			Frede			Fred	derick
	Funeral			. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year		Date of Birth (Month, Day, Ye		Birthplace (State or Foreign Country)
	Director		556-36-4133	1□M 2 <b>⊠</b> F	97 Yrs.	Months Days	Hours Min.	Feb. 6 $1$	.910	Austria
	D D		Usual Residence of Decedent							
	uylar show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1   Yes 2 □ No
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	or 2	Director	10e. Street and Number			10f. Zip Code	04-0-		Citizen of Wha	
	er deeth with the Maryland teme 23s or 28s-f show er mast be nutilised at	ra	7407 Willow Roa				21702		United	States American Indian.
		Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🗷 No	ver in U.S.	If Yes, specify Cubar	spanic Origin? (Specify n, Mexican, Puerto Ric	an, etc.)		White, etc.
5	rs aft	by F	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No	Specify:		Specify:	White
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7	time of the	Completed	8	0	Aı	nimal Care	taker		Health	Institute
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/land	uld be Vental rked c	To B	Joseph Larche	er			Armeni	.a Sep	pi	
Mary	Peges 1 and 2 should be filed with intent of Heilth and Mental Hygiene. ant: If item 27 is marked other than wry or other traumatic event, ITEM	1 1	19a. Informant's Name/Relationship			-	nd Number or Rural R			
_	and and in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 27 in 2		Ronald L. House	: / Nephew			Road, Fred			.702
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					9 - 1
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	pe #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
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מ	death e etten id for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
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o .	law rec as bee 2 shou	lete	Can a stin	e hourt &	a fun	Namas	ille.	24a. Was an	24b. Wer	e autopsy findings available
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5	Physician: this certific ral director,	0 8	examiner? 1 Yes 2 No	Hospital:	it 2□ER/Outpatie	nt 3 DOA Othe			e 6 □Other (	Specify)
		n: T	27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury Work		l. Describe how i		
SION	Attending ir death. ector; After by the fune	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat		, oar, injury		es 2 □ No			
	ar de recto by th	E C	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injurbuilding, etc.	ry - At home, farm, st	reet, factory, office	28f.	Location (Stree City or Town, S		or Rural Route Number,
5	rs eft at Di	Certification:								
	the Hospital or nin 24 hours efte the Funeral Dir npletely filled in	edical	(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	examination and/or in	h occurred at the time vestigation, in my op	e, date and place, and inion, death occurred	l due to the caus at the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s)
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certified	and manner stat	ed.	29c. License				Nonth, Day, Year)
	Z E E		255. Signature and interior certifier	Wehlen.	MALTA	n n	20-10-2	1		-10
(	<u></u>		MAT	yellor	cour	20	>>/8/	The	nuar	10,0008
-			30. Name and address of person wh	o compreted cause of de	atn (Item 23a) (Type,	of alla	trant o	Francis	and of	MT
	Sta	te	81. Date filed (Month, Day, Year)	32. Registra	s Signature	1 7 2	VICEI	1240	1100	• • • • • • • • • • • • • • • • • • • •
	Registr			[ 4 2008 ▶ /	seure 15	Sparke				

T.O.D. 16:30

Dob.1/9/08

Known to originans as metholown, Alora

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Shanna Marie Osar		Stat For State	e of N	/larylan		•	ment of <i>ficate of</i>			Menta	al Hy		eg. No.	20	n c	) (	121
Division	R	egistrar . Decedent's Name (First, Middle,t	ast)			Certii	icale of	2. Date of						20	3.	Time of	Death
Physician/ Medical Examine			-	Marie	Osaı	ni						Month January 6	Day , 2008			1529 h	nrs
got lan	4	a. Facility Name (if not institution, Conowingo & Henderso			er)			b. City. Bel	Town, or L	ocation of	Death			County of Dea arford	ath		
Eurogal	5		Sex		Age (In	vrs. last	birthday)		der 1 Year	If Under	24Hrs.	8. Date of Bi		DD/YYYY) 9. I	Birthpl	lace (Sta	te or
Funeral Director	1			2x F	, igo (	23	Yrs	Mon		Hours	Min.	April	,	For	eign Counti	Mary	land
	t	Jsual Residence of Decedent			-					L							
v any	1	0a. State 10b. County			10c.	City, To	own or Locati	on									City Limits
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to the Maryland to the Maryland to the Maryland to the the the the the the the the the the		Oe. Street and Number	110	Pond				101. 2	ip Code	21019	2	İ	Citizen of What Country?  U.S.A.				
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or items 23 . must be no		1 X Never Married 2 Marr	ied 1	Armed Force	es?	No	If Y	es, spe	cify Cuban,	Mexican,	Puerto F	Rican, etc.)		White, etc			
s after or rall, or niner n			or Da	s, Give Year etes:			1		2 X No					Specify:		ite	
hours hatur Exam		15. Decedent's Education (Specif Elementary/Secondary (0-12)	on (Specify only highest grade completed) 16a.						al Occupation orking life.				16b. K	(ind of Busines	ss/Indi	ustry	
-0036  within 72 hour giene. her than "natue Medical Exanormaleted		Twelve Years									Stu	den	it				
5-0036 lied within 7 Hygiene. I other than the Medica	5	17. Father's Name (First, Middle, L	est)						1	8.Mother's	s Name (	First, Middle,	Maiden	Surname)			-
2121: ould be fil Mental I marked ic event,	ונ	Dougla			Osa:	ni	405 Mailia					Judy M		cken ity or Town, St	oto 7	in Code)	
MD 21 d 2 should tht and Me n 27 is ma rumatic er	1	19a. Informant's Name/Relationshi Judy Mountain				_	,					.go, Ma					
e, M and 2 Health Item 2	- 11	20a. Method of Disposition				20b. Pla	ce of Dispos	ition (N	ame of cerr			Date		Location - City			
nor ages l ant of l		1 X Burial 2 Cremation 4 Donation 5 Other Spe		emoval from	State		matory or ot Nottin			ry	01/	/11/08	Co	lora, N	/ar	ylan	d
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		21. Signature of Funeral Service L	sensee	0 00		_	22. N	lame a	nd Address	of Facility	n &	Son Fi	nera	al Home	. ]	P.A.	
W F F E		MONOW A	ret	RIXI	13	W.	Pe	rry	ville	, Mar	ylar	nd 2190	3-0	766	,		nate Interval
Physician M dical		23a. Part I. Enter the disease, or confailure. List only one cause of	each lin	e.		death. L	o not enter t	ne moa	e or aying, :	such as ca	ardiac or	respiratory a	rest, sin	ock, of fleat	3	Between	Onset and Death
xaminer																	
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line.		if any, leading to immediate cause. Enter Underlying Cause	y, leading to immediate Due to (or as a consequence of): e. Enter Underlying Cause														
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Sox 6876( death certificate e attending phys I for use as the b	5 2	3b. Was decedent pregnant in the past 12 months?	Ι.	Live birt		e of deat	_ =	etal dea		Ectopic	pregnar	псу		Month	Da	У	Year
D. Box the death of the death of by the attentached for us		1 Yes 2 No 9 V Unkn	own 9	= -		0.000	n 5 0	ther (S	ресіту)								
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itendir teath. tor: A	9	Natural 5 Pendii 2 Accident Invest	ng gation	Jan 6, 200	08'		1527 hrs		1_1	′es 2 <b>√</b>	No						
Division o Spital or Attending tours after death. neral Director: Aft filled in by the fune	<u> </u>		not be				ne, farm, stre	et, fact	ory, office b	uilding, et		or Town	State)	and Number o lerson Road			Number, City
6 4 5 1 1/98 Lentiller 1																	
To the How within 24 b To the Fun completely	2	(Check only one) 2 Medical Exam	iner:On	the basis of manner sta	examina	ation and	d/or investiga	ation, in	my opinion	, death oc	curred a	t the time, da	te and pl	ace, and due	to the	cause(s)	
To To Sor	_	29b. Signature and title of certifier	1	1					29c. Licens					Date signed		h, Day, Y	ear)
		In	11	1/2					O.C.I	M.Ē.			Jar	nuary 7, 20	80		
		30. Name and address of person v Jack Titus MD. Depu		leted cause of Medica		,	-	nn St	reet, Bal	timore.	MD 21	201					
/O	(e.	31. Date filed (Month, Day, Year)	200	32. R		Signatur											
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2008 Terry L. January 2:15 P M 0gle /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 7104 Hillside Circle Frederick Thurmont | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | May 13, 1945 5. Social Security Number 6. Sex. 1 ☐ M 2 ☐ F 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Funeral 220-42-7478 62 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 🏋 No notified Director 28a-f Frederick Maryland Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 7104 Hillside Circle 21788 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", permit. Pages 1 and 2 should be filed within 72 hτ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. once. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Manager Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert B. Ogle Helen M. Barrick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7104 Hillside Circle, Thurmont, MD 21788 <u> Marjorie Ogle / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Mount Tabor Cemetery 1/12/2008 Rocky Ridge, Maryland 4 Donation 5 DOther (Specify) 21. Signay of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 104 East Main St., Thurmont, MD 21788 23a Part1. Enter the disease or complications that daised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** runshot Wound /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dissilt. Urras a prosecucinos ofi Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ≥ 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ▼No 24a. Was an page 2 s autop performed 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 1 Ves 2 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Division 5 Pending investigation 1 Natural Subject January 8 2008 Unknown 1 Yes 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 28e. Place f injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town State) Ate To the Hospital or within 24 hours at To the Funeral D home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

WHIN.

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type,

ohrer

JAN 1 4 2008

31. Date filed (Month, Day, Year)

08-00478		Please Type or Print in Black Indelible Ink. Ensure All Copie		jible.				
Chance A Pritcha		State of Maryland / Department of Health and Mental H	ygiene	200	0 0101			
		I- For State Certificate of Death		g. No. 200	0 0101			
Physicia	-	1. Decedent's Name (First, Middle,Last)	Date of Death     Month	Day Year	3. Time of Death			
Medical Examin		Chance Anson Pritchard	January 17	7, 2008	1100 hrs			
( )		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8801 Loch Raven Blvd Rm. 409 Towson	on of Death  4c. County of Death  Baltimore County					
4	4							
Funeral Director		Months Days Hours Min	der 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign					
Director		500-92-1492 1XM 2F 32 Yrs.	Novemb	per13,199	ptryM1SSOUT1			
,	F	Usual Residence of Decedent			10d. Inside City Limits			
w any		10a. State 10b. County 10c. City, Town or Location	_	1	1 Yes 2X No			
land f sho	5	Missouri Pemiscot Caruthersvil						
day San	Sec.	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coun	ry?			
h with the M	Funeral Director	990 State Highway D 63830	Ţ	J.S.A.				
15-0036 filed within 72 hours after death with Hygiene. ed other than "natural", or items 233 i, the Medical Examiner must be no	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S. Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,			
death death	ĔΙ	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Ricari, etc.)					
after al", o	<u>8</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify:		Specify: Whi	ce			
natur	훘[	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business/Ir	dustry			
6 - 72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	1100)	Farming				
or the	튑	4 Farmer		Farming				
5-0 lled v Hygir		17. Father's Name (First, Middle, Last)  18. Mother's Name						
121   be fil   ental J   arked	å		ecca Bo	-				
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	의	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Num	nber, City or Town, State,	Zip Code) 63830			
MD id 2 sho alth and m 27 is		Rebecca Pritchard/Mother 990State Highway D		hersville	Missouri			
re, free free free free free free free f	-1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Iown, State			
Pager o ent o	Ц	4 Donation 5 Other Specify: Little PrairieCem.		Caruthers	ville, MO.			
Baltimore, permit. Pages I ar Department of the Important: If the injury or other tr	ı	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ma	rzullo	Funeral (	hapel P A			
E P E	Ц	makail Marsullo ¢009 Harford Ro	ad,Balt	timore, Mar	yland2121			
Physician		25a. Part I. Enter the disease, of implications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and			
/Medical	-	failure. List only one cause on each line.  Immediate Cause (Final disease a Narcotic intoxication (morphine)			Death			
xaminer		or condition resulting in death)  Due to (or as a consequence of):						
	.	Sequentially list conditions, b.						
	힐	if any, leading to immediate Due to (or as a consequence of):						
	ΞĮ	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last						
150 B IE	cal Examiner	events resulting in death) Last Due to (or as a consequence of):						
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376 fficate g phy s the	٥	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant	ancv	23d. Date of delivery	ay Year			
certi certi endin use a	ia.	past 12 months?    1   Live birth   2   Fetal death   3   Ectopic pregn     4   Pregnant at time of death   5   Other (Specify)	3,10)	1	.,			
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es th.	Completed by		1 Yes	s 2 🗸 No 3 Prob	ably 4 Unknown			
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COI law i has t	ם		autop perfo	rmed? prior to c rmed? death?	ompletion of cause of			
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Division of Vital Records, P.O. Is tall or Attending Physician: The law requires that the Irs after death.  "al Director: After this certificate has been signed by the funeral director, page 2 should be deached.	ဍ	1 V Yes 2 No		Residence 6 V Other	: Scene			
Afte		27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred				
ior ttend death ctor: y the	<u>اڅ</u>	Accident Investigation Find 1/17/2008 Find 10:52 am	unk					
or A after Dire	읣	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru State) Ba1				
D pital ours cours	je.	4 Homicide determined (Specify) Motel	8801 Loc	state) Bal h Raven Blvd,	Rii 409'			
e Hos 24 h e Fun	ja ja	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial - transit	Medical Certification:	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to th	e cause(s)			
Fara	žΓ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo.	nth, Day, Year)			
		Man Branell MV) O.C.M.E.		January 18, 2008	3			
	ł	30. Name and address of person who completed cause of death (Item 23a)	77-					
9	1	Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201					
Sta	te	31. Date filed (Month, Day Yeer) 2018 32. Registrar's Signature						
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			1 _ For	State of M	laryland / De		of H	ealth a		•		nna	018	18
			Registrar  1. Decedent's Name (First, Middle, L	nati		ertificate	of L	eath			ag. No.		010	
ı	Physici	an		•						Date of Dea Month	Day	Year	3. Time of	
	/Medic Examin		Preston Carroll  4a. Facility Name (If not institution, g		·)	4b. City, To	own. or	Location o		anuary		2008 County of Dea	12:43	P M
	Exami	iei	Northampton Mano			Frede						derick		
	Funeral			Sex 7. A	ge (In yrs. last birthda	y) If Under 1	Year	If Under 2		Date of Birth (Month, Day	)		thplace (State of cuntry)	Foreign
	Director		218-12-3720	1 <b>X</b> M 2□F	87 Yrs	Months	Days	Hours					ryland	
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside Cit	v l imits
	Manyl f ehc	ō	Maryland Frederic	-1-	Frederick								1 📉 Yes	•
	7 288	Director	10e. Street and Number	SK.	riederick	10f. Zip C	Code			1	0g. Citize	en of What Co	ountry?	
	h with	<u>=</u>	613 Biggs Avenue			2170	12				USA			
	deed T	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 1	3. Was Deceder		spanic Orig	gin? (Specify	Yes or No-		Race - Ame Black, Whit		
36	or it	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 🔀	No	1 □ Yes 2		Specify:	, , a o	, 010.7	S	necify:		
21215-0036	within 72 hours after deeth with the Maryland ene. then "netural", or iteme 23e or 28e-f ehow he Madical Examiner must be notified at	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:		cedent's Usual	000000	eine.				wn		
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2	al Hy al Hy of the	BeC	17. Father's Name (First, Middle, Las	st)				18. Mother	r's Name (Fi	rst, Middle, i	Maiden S	umame)		
yla	Ment Ment arkec	2	Abram Garfield Po	oole				Annie	Rebe	сса Ма	in			
Maryland	2 sh and ie m		19a. Informant's Name/Relationship		19b. Ma	iling Address (	Street a	nd Numbe	r or Rural Ro	ute Number	City or	Town, State, .	Zip Code)	
	1 and Health em 27 ther t		Anna Mae Poole, o	daughter	20b. Place of Dis	Biggs A		ue, F	reder				21702	
٥	nt of h		1 XBurial 2 ☐ Cremation 3		cemetery, c	rematory or oth	er place					ation - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "netural", or Iteme 23a or 28a-f ehow ery injury or other traumatic event, the Madical Examiner must be notified at one.	1	4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Pleasant									
Ba	Depa Impo eny i		Novert L.	Helles	mr	26401 R	Ridg	e Roa	id, Dan	mascus	, Ma		Funera1 20872	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause y one cause on each l	d the death. Do not dine.	enter the mode	of dying	, such as o	cardiac or re	spiratory arr	est,		Approximate Interval Betw Onset and D	reen
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	Civilia	- 20	en	nio					years	
H	Examiner		1	Due to (or as	s a consequence of):									
	*	ē	Sequentially list conditions, any, loading to immediate	b. — Due to (or as	a consequence of):									
	od ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.										
760,	te be executed ysicien end ie burial-transit		resulting in death) Last	Due to (or as	a consequence of):									
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89 x	ding p	Me	IF FEMALE:	23c. If yes, outcome	of programmy									
O. Box	eath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	B □Ectopic preg					23	<li>d. Date of del Month</li>		ear
o.	the d y the ached	ysl	1  Yes 2 No 9 Unknown	9□ Unknown		Other (spec		-						
œ.	Attending Physicien: The law requires thet the death certifica rideath. clor: After this certificate hes been signed by the ettending proy the funeral director, page 2 should be detached for use as it	by Physician/Med	Part II. Other significant conditions	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	out not resulting in the	underlying cau	ise giver	n in Part I.		23e. Did tob	oacco use	contribute to	the cause of de	ath?
ğ	w require been sig should b		Degi	rentwe	font	Disco	se		_	1 □ Ye	s 2 🗆	No 3□Pr	obabiy 4 💢	ńknown
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/ita	cien: ertific actor.	Be (	25. Was case referred to medical examiner?				_		of Death (C)		-			
5	Physi this c	۵	1 ☐ Yes 2 📉 No	Hospital: 1  Inpati				4 A IAUI				Other (Spe	cify)	
Division of Vital Records,	if or Attending Patter death. Director: After t	9	27. Manner of Death  ¹ XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury	of 28c	Work?	at ? es 2 ⊡N		Describe ho	w injury	occurred		
<u> </u>	deatl deatl ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not	De Diese of le	jury - At home, farm,			62 Z 🗆 IV		Location (St.	reet and	Number or Ri	ural Route Numb	ner
2		Certification;	4 ☐ Homicide determined	building, e	tc. (Specify)	o., o., rasiory, c	,,,,,,			City or Town	, State)			J.,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edlcal (	29a. Certifier 1 Cartifying P (Check only one) 2 Madical Exa	hysician: To the best minar: On the basis of and manner si	of examination and/or	ath occurred at investigation, in	the time	e, date and nion, death	place, and h occurred a	due to the ca t the time, da	ause(s) ar ate and p	nd manner as lace, and due	s stated. to the cause(s)	
	To the within 2. To the I complet	Me	29b. Signature and title of shrifter	MM	- hx			number 244	199				h, Day, Year)	
	\		30. Name and address of access the	completed sc f	death (line on ) (T		0	10/	//	J	lanua	ry 14,	2008	
L	+		30. Name and address of person who Ronald E. Mille		#4 Culwell		, Mo	unt A	Airy,	Maryla	ınd	21771		
	Sta		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature									
	Registra	ar	JAN 1 4	2008	is to the	Contr								
DILL	41.1 47 Day 4700	04												

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Anna Mary Pickett Sanuara 300% /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hosptial Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. Director 83 July 14, 1924 Maryland 577-32-7793 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Gaithersburg Maryland Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 24415 Woodfield School Road 20882 Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or iten raumatic event, the Medical Exa⊞iner 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 bookkeeper Highway Consulting Firm other traumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Joseph Montgomery Duvall Dora Blanche Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I Paulette McGraw, daughter 3393 Grade Road, Falling Waters, West Virginia 25419 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation Other (Specify) Metropolitan Crematory 1/9/2008 | Alexandria, Virginia 21. Signature of Fun ral Service Licensee 22. Name and Address of FacilityMolesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or Additional resulting in death) AIRWay diseas Physician obotructive. 14ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, frame, leading to improve cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): certificate be executed burial-transi Exami and resulting in death) Last Due to (or as a consequence of): physician as the burial-Box 68760, Physician/Medical use as nding ! IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year signed by the at d be detached fo 4☐Pregnant at time of death 5 Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🙀 🗂 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1∐ Yes 2□No 2/ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending investigation I Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 28365 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Strat Hagestam 1902/140

Registrar DHMH 17 Rev 1/2001

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1 ANZ AR. 31. Date filed (Month, Day, Year) 368

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Wendell Archer Potter 534 /Medical 2008 -Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Sausbury n If Under 1 Year | If Under 24 Hrs. MI Birthplace (State or Foreign Country) **Funeral** Vear Days Hours Min. 220-12-1079 1 🛣 M 2 □ F 82 Director 11/19/1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 229 Canal Park Drive 21804 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Navy 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 👿 No Specify: 3 □ Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 owner/operator concrete products permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important; If item 27 is marked other i any injury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wendell Chester Potter Elizabeth McCann 19a. Informant's Name/Relationship (Type. Print)
Michael Potter/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Loch View Ct., Timonium, MD 21903 20b. Place of Disposition (Name of cemetary, crematory or other place)
WICOMICO Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 1/11/08 4 □ Donation 5 □ Other (Special Salisbury, MD Park 21 Signato e of Fun ral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Party. Enter the disease, or complications that caushock, or heart failure. List only one cause on pac d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** EREBRAL HEMOZILITAGE /Medical Examiner typ GZTGUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEWMONIA 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**1**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P5733 2008 8

State Registrar

Pierre

31. Date filed (Month, Day, Year) JAN 11

DHMH 17 Rev 1/2001

SALISbury

md. 21801

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

dRW 10

Alicia Thakor Mistry, M.D. 9901 Medical Center Drive, Rockville, MD

Registra Signature

2008

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			1 - For State Registrar	State o	f Marylan			t of H	ealth a	and M		_	)8	01822	
ı	Physic	ian	Decedent's Name (First, Middle, Last)     Coate of Death     Month Day Y										Year	3. Time of Death	
	/Medi		Montin Tohn Discussion											7:15 A M	
7	Exami	ner									4c. County of Death				
			Spa Creek Center					Annapolis If Under 1 Year   If Under 24 Hrs.   8 Date of B				Anne Arundel			
	Funeral		5. Social Security Number 110-18-2216	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. ) 82	last birthday) Yrs.	Months	1 Year Days	If Under:	Min.	8. Date of Birth (Month, Day 8/14/1	Year)	Cou	place (State or Foreign intry)	
	Director		Usual Residence of Decedent		02	113.		-			8/14/1	.925	Nev	v Jersey	
	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		10a. State 10b. Coun	ty	10c. City	y, Town or Lo	cation							10d. Inside City Limits	
		to	Maryland Anne Arundel Annapolis											1 ☐ Yes 2 X No	
		irec	10e. Street and Number 10f. Zip Code							1	0g. Citizen of	What Cou	intry?		
		a D	2544 Sandy R	un Ct.				2140	1			USA			
		ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?					Was Decedent of Hispanic Origin? (Specify Yes or No f Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.			
9		/Fu	1 Never Married 2 Ma	rried 1 X Yes	2 🗆 No	1	1 ☐ Yes 2		Specify:	, ruelto i	nican, etc.)				
21215-0036		Completed by Funeral Director	3 □ Widowed 4 □ Divorced Year or Dates: 1943-46								<i>ty:</i> Whi				
5		lete	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							16b. Kind of E	Jusiness/Ir	ndustry			
12		m d	Elementary/Secondary (0-12)  College (1-4or 5+)  4 years  Deputy Chief							Law Enforcement					
		ပိ	17. Father's Name (First, Middle		5	рерц	Ļy UII.	тет	18. Mothe	r's Name	(First, Middle, M			cement	
an		To B		in Riordan								h Dillon			
Maryland		1	19a. Informant's Name/Relation			19b. Mailir	a Address	(Street a	nd Numbe			er, City or Town, State, Zip Code)			
			Catherine T. R		fe						napolis	-		5 0000)	
Baltimore,			20a. Method of Disposition		20b. P	lace of Dispo emetery, cren				70000000000		20c. Location		own, State	
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ä			4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 1/9/08 Crowns  21. Signature of Facility George P. Kalas F								, A T T T	1 II.			
Ö			> /Whit //	11/		20	973 Sc	10ma	ons T	clan	d Rd. Ed	garas t	unera m	ar Home	
	¥		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that c	aused the death	n. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	est,	المصولة	Approximate	
	/Medical Examiner		Immediate Cause (Final	7	. O. t.	- <del>-</del> -								Interval Between Onset and Death	
1			disease or condition resulting in death)  Due to (or as a consequence of):								Trackeres				
			Sequentially list conditions, it immediate cause. Enter Underlying  Due to (or as a consequence of):  Due to (or as a consequence of):								months				
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	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of by												
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ō	tel or A s after el Dira ed in b	Certification	4 Homicide building, etc. (Specify)  City or Town, State)												
	To the Hospitel or Attanding within 24 hours after death. To the Funerel Diractor: After completely filled in by the fune	dical	29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	viedge, death	occurred a	t the time	e, date and	place, a	nd due to the ca	use(s) and ma	inner as s	tated.	
	To the H within 24 To the F complete	0	and manner stated.									and due to	une cause(s)		
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	(2) (Q)		30. Name and address of person	who completed cause	e of death (Item	23a) (Type, F	rint)	Hui	ng /T	ran,	Davis		- 1	21403	
	-		SPAC	reek C	enle		35	MI	IKS	19K	chan	ie Al	Map	5/15 MD.	
	Sta		31. Date filed (Month, Day, Year	9 2008 32.	gistrar's Signati	ure	1	_					/		
	Registr	ar	JAN V	J 7000	Men ,	O B	BALL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1115AM GRACIE VIRGINIA ROBERTS January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC 22, 1931 Birthplace (State or Foreign Country)

W 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours Min. 1 □ M 2 1 F 76 233-48-6605 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f shiner must be notified 1 ☐ Yes 2 No Director WASHINGTON MARYLAND SHARPSBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2551 CHESTNUT GROVE ROAD 21782 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 🔨 Year or Dates: 1 ☐ Never Married 2 Married 0 "natural", or edical Exaπi Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than OFFICE MANAGER ELEC. MOTOR REPAIR CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ ERNEST DODSON JESSIE JENKINS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau ALLEN M. ROBERTS, HUSBAND 2551 CHESTNUT GROVE ROAD, SHARPSBURG, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1√2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Dopartor 5 □ Other (Spenty) 5 ☐ Other (Spegify) SAMPLES MANOR CEM. 1/15/2008 SHARPSBURG, MARYLAND 21. Signat 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND Paul M. Dean P the Enter the disease, or shock, or heart failure. List replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Immediate Cause (Final Physician Keyriralor disease or condition resulting in death) /Medical Due to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nnusemi (or as consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/ No funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Tes 20 No 1 Tinpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No s after death 3 ☐ Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: completely within 2 The F

> State Registrar

29b. Signature and title of certifier

(Item 23a) (Type, Prir Nuand

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No ZUU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Koberts 02 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Somerse McCready Cristicle, Mary Hospital Memorial land If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 8-3-Director s filed within 72 hours after death with the Maryland II Hygleine. other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Salisbury 1 Yes 2 No Wicomico Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 E. LONDON Avenue Funeral . Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: BIACK þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Perdue Elementary/Secondary (0-12) College (1-4or 5+) Control 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Kellam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Michelle C. Roberts P.O. Box 56 28667 Fairmont Rd. Manokin, Md (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/12/08 Centeniel Church Cem Upper Fairmont, Md W. Isabella St 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
BENNE SMITH
FUNELAL HOME 21. Signature of Funeral Service Licensee SAlisbury, md 21801 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, of feart failure. Immediate Cause (Final disease or condition resulting in death) ardiovascular **Physician** unknown /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed hest physician and s the bunal-trans Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number D0047426 8005/01/10 Medical Director Med Director 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mc Cready Menonal Robert Klug, MD.

32. Registrar's Signature

Here & forth

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

JAN 11 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Elizabeth Schwartz Frances January 7, 2008 6:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X** F 73 Director 579-48-7409 Washington, DC 9, 1934 Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Prince George's Beltsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4305 Usange Street 20705 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. 2 white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nashwinter Dorothy Elizabeth ဥ Alfred Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4305 Usange St., Beltsville, MD 20705 Joseph Schwartz, Sr., husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 01-10-2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart builder. List only one cause on each line. Immediate Cause (Final **Physician** CARCINOMA resulting in death) /Medical Due to (or as a consequence of). Examiner obstructive monary disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lorence Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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State Registrar

(Check only one)

29b. Signature and title of certifier

S. M. NAYAR

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MP

COTTAGE CITY.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

MD 20722

1-9-2008

within 2

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			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Hea rtificate of De		, ,	ene g. No. 🤈 🗎 🗎	0 01026
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	/Medio	al			drey Smith		antian of Dooth	January	3, 2008	6:00 A M
	Examir	er	<ol> <li>Facility Name (If not institution, give 9230 Owings Manor Co</li> </ol>			4b. City, Town, or Loc Owings	cation of Death		4c. County of D Calvert	eatn
,	Funeral Director		5. Social Security Number 6. Social Security Number 1		e (In yrs. last birthday) 94 ^{Yrs.}	If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October 2	Year)	Birthplace (State or Foreign Country) ID
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Maryland		•	19a. Informant's Name/Relationship (7			ng Address (Street and				e, Zip Code)
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mor	Pages nent of l		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, crer	natory or other place)  1 Church Ceme		_		
Baltimore,	permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licen			2. Name and Address o		08	Sunderland,	MD
m —	9 2 2 5		Sladys a.	Sewell						derick, MD 20678
	Physician /Medical Examiner	ler	23a. Part1. Enter the disease, or companies shock, or heart failure. List only a limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. COMPLI Due to (or as	a consequence of):					Approximate Interval Between Onset and Death
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ō	Physer this eral dir	5	1 Yes 2 140	28a. Date of Inju	nt 2 ER/Outpatien  ry 28b. Time of	IL 3 DOA			nce 6 Other (5	specify)
0	nding ath. r: Afte ie fune	ation	1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Injury		2 □ No		. ,	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, the funeral director, and the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director, the funeral director director, the funeral director director, the funeral director director director, the funeral director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ury - At home, farm, str c. (Specify)			City or Town,	State)	Rural Route Number,
	the Hospi in 24 hour the Funer tpletely fill	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of the basis of and manner sta	of my knowledge, death f examination and/or in tted.	vestigation, in my opini	on, death occurre	d at the time, da	te and place, and	due to the cause(s)
	To With	2	29b. Signature and title of certifier			29c. License nu			d. Date signed (M	
•			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	D 26	5) 8		TAN.	5.2008
de	y) a Sta	te	TAHAL H W	IFTGFL	MD - D	DINGE F	れらら	rick,	M)-2	0678
	Registr	ar	31. Date filed (Month, Day, Year) JAN 0	3 ZUU8	Frence &	fronts.				
DH	MH 17 Rev 1/2					*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Arthur Mace Smith January 10 2008 1:17 p. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 109 Talbot Avenue Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 15 M 2□F Yrs Director 215-14-3092 85 April 16, 1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any liquity or other traumatic at a more. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No MD Dorchester Cambridge Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 109 Talbot Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) loom operator wire cloth mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Smith Mary Ruth Edwards 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Hurley daughter 2945 Third St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 4 Donation 5 Other (Specify) 1/16/08 Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee B-16-18 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eukenia 41.3mg disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 1□ Yes 2 XNo 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 🔀 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: Jopital ... 4 hours after de... reral Director: Andre ... 

> State Registrar

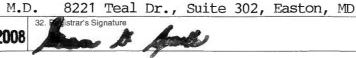
31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

David H. Smith,



29c_License number

29d. Date signed (Month, Day, Year)

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Q Month Year Physician <u>2008</u> Simmons Ebert Reece Dirich /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) mondae If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 217-30-7543 Feb. 26, 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo Director Dorchester Church Creek 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4111 Golden Hill Road 21622 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mechanic automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Everett Simmons Carrie Elizabeth Hurlev ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Simmons wife 4111 Golden Hill Rd., Church Creek, MD 21622 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐Cremation 3 ☐Removal from State Dorchester Mem. Park 1/12/08 4 □ Donation 5 □ Other (Specify) Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. k. E 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 has disease or condition resulting in death) Due /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page. perform lachycodia 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10,2008

Registrar

State

Simons

408 Byrn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.M.

2008

32. Red

Mallins

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of State of Registrar	f Maryland / Dep <i>Ce</i>	ertificate of D			ene 2008	01829
Ė	Physici /Medi		1. Decedent's Name (First, Middle, Last) William Leroy	y SCHULTZ, S	SR.		2. Date of Death Month January	Day Year	3. Time of Death
de	Examir		4a. Facility Name (If not institution, give street and num 11717 Meadowlark Avenue	nber)	4b. City, Town, or L Hagerst			4c. County of Dea Washingto	
	Funeral Director		218-30-8690 ¹™ 2□F	7. Age (In yrs. last birthday, 72 yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 7,	Year) Co	hplace (State or Foreign buntry) cyland
	death with the Maryland ms 23a or 28e-f ehow Emust be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washington	10c. City, Town or L Hagerstow					10d. Inside City Limits 1 ☐ Yes 25 ☐ No
	with the	i Direc	10e. Street and Number 11717 Meadowlark Avenue		10f. Zip Code 21742		10	g. Citizen of What Co	ountry?
350	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene 1 Health and Mental Hyglene 1 Health and Mental Hyglene 2 how Item 27 is marked other then "nature!", or items 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified at	by Funeral Director		rces? 2  No e	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Ame Black, Whit	
1215-0036	within 72 hou ene. then "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	16a. Dece (Give life.	edent's Usual Occupati e kind of work done du DO NOT use retired)	ion ring most of worki	ing	6b. Kind of Business	Industry
	be filed within tal Hygiene. d other then "	Be Co	17. Father's Name (First, Middle, Last)		wner	8. Mother's Name	e (First, Middle, M	inn aiden Sumame)	
aryla	should be nd Mental marked o	7	James Lincoln  19a. Informant's Name/Relationship (Type, Print)	Schultz 19b. Maili	ing Address (Street an	d Number or Rura		Pearl Baug	
ге, ма	s 1 and 2: f Health ai ftem 27 is other treu		Susan K. Schultz - wife	1171	7 Meadowla	rk Avenu	e, Hager		ryland 21742
E III	t. Page tment o rtant: If ijury or		1 ☐ Burial 2 【★Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Hagersto	wn Cremato	ry 3 anua	08 Н		, Maryland
מ	Depar Depar Impor any ir		Fred LiVestel	4		lson Blv	d., Hage		nome aryland 21740
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  b.	or as a consequence of):	iter the mode of dying,	such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
,00,	eath certificate be executed attending physicien and for use as the burial-transit	edical Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):					
O. BOX 00	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours atter death.  On the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it.	Physician/Medi	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
L (Sp.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	inderlying cause given	in Part I.	23e. Did toba	cco use contribute to	
מו חפכר	sician: The law re certificate has be rector, page 2 sho	e Completed	25. Was case referred to medical				/	prior to death? No 1 ☐ Yes	topsy findings available completion of cause of
	ding Physicia h. After this cert funeral direct	ToB	examiner?  1 Yes 2 No Hospital: 1 In In  27. Manner of Death 28a. Date of (Month)  Natural 5 Pending	patient 2 ER/Outpatier f Injury 28b. Time o n, Day Year)	nt 3 DOA Other:  28c. Injury at Work?	4 Nursing Hor	ne Residen 28d. Describe how	ce 6 □Other (Spec	cify)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of	of Injury - At home, farm, str g, etc. (Specify)			28f. Location (Stra City or Town,	et and Number or Ru State)	ral Route Number,
	n 24 hou n 24 hou he Funer	Medical	29a. Certifier (Check only one)  Certifying Physician: To the base and manner	sis of examination and/or in	h occurred at the time, vestigation, in my opin	date and place, a tion, death occurre	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To t withi To ti comp	Σ	29b. Signature and title of certifier.	a ade	MD 29c. License n	1647 -	290	1. Date signed (Month	Day, Year)
5 t	1-10+1		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	CT	Hage	2 stores	m) 217/10
1.66	Sta Registra		31. Date filed (Month, Day, Year)  JAN 1 4 2008	distrar's Signature	berli	<u> </u>	1113	(DIEWII)	112 21140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene B.A. WCHD Amended item For State Registrar #23a, Part I, a, b, c per phys., Certificate of Death 1/11/08 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Frederick Wayne Savage 12:25 PM 5 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury Vicinic Kegional Medical 3. Date of Birth (Month, Day, Year) 11/18/1946 5. Social Security Number . Age (In vrs. last birthday If Under 1 Year | If Under Birthplace (State or Foreign Country) **Funeral** Months 10X M 2□ F Davs Hours 61 215-44-7088 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits 28a-f show 1 □Yes 2 TXNo Examiner must be notifled Director MD Worcester Ocean City 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with to and Mental Hygiene.

is marked other than "natural", or items 23a or 2 12630 Old Bridge Rd. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4XXX Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Realtor Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert J. Savage Doris Birch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Doris B. Savage / mother 12630 Old Bridge Rd., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If Ite any Injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Cemetery 1/10/2008 Berlin, MD 4 □ Donation 5 □ Other (Specify) f Funeral Service 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** egun 10hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiogenic Shock if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed Coronary Artery Disease attending physician and for use as the burial-trar Due to (or as a consequence of) 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the s o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying use given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? 1 ☐ Yes 2 ☐ No. certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only on Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P or 27. Manner of Peatl 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: or Attending 5 ☐ Pending investigation Month, Day Year) 1 Natural Division Injury 1 ☐ Yes 2 ☐ No Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death are 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month. Dav. Year) son who completed cause of death (Item 23a) (Type, Print) BA 6+1 20 MD 31. Date filed (Month, Day, Year, 32. Begistrar's Signature State Registrar JAN 1 1 2008

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryla	ind / Depa	artment of H	lealth and N	lental Hygi	ene 008	01831
Physi /Mer	ician dical	Decedent's Name (First, Middle, Last)     Marquerite 1	1. Schorr				2. Date of Death Month January	Day Yeer 10 2008	3. Time of Death 4:00 A
Exam		4a. Fecility Name (If not institution, give s Sunrise Assisted I	rreet and number)		4b. City, Town, or  Columb  If Under 1 Year	Location of Death		4c. County of Dea Howard	th
Funera Directo		5. Social Security Number 6. Sex 218 01 7535	M 2⊠F 92	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, ) June 24,	1915 Ma	thplece (State or Foreign ountry) Lryland
he Maryland 8a-f show	ector	10a. State 10b. County MD Howard		city, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
LING X IX IS TO SO TO SO THE TO SO THE MATCH WITH THE MATCH AND THE HIGH HIGH HIGH WITH THE MATCH WITH THE SO TO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO TO SO T	led by Funeral Director	3 Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1	16a. Dece	10f. Zip Code  2104  Was Decedent of Hill Yes, specify Cuba  1 ☐ Yes 2☐ No  dent's Usual Occup:	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	g. Citizen of What C  United St  14. Race - Am Black, Whi  Specify: Wh  6b. Kind of Business	ates ancan Indian, le, etc.
A I A I D-0050 d within 72 hours af giene. er then "natural", or the Medical Exam.	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired memaker	during most of work	sing	Own Home	•
ed la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last) George V. Fowble				18. Mother's Nam Marie Mo	e (First, Middle, Ma orgereth	aiden Sumame)	
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke eny injury or other traumatic		19a. Informant's Name/Relationship (Type George H. Leinewebe 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	er/Son  emoval from State  Property of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	Place of Dispo cemetery, cres arkwood 044	5 Carillo esition (Name of matory or other place Cemetery 2. Name and Address	on Drive I	Ellicott Date 20 -2008 B ry H. Wit	City or Town, State, City, MD Oc. Location - City or caltimore, czke's Fam	21042 Town, State
Physician Persecuted (Medicale persecuted by Physician and Physician and Physician at the Purial-Iransit	ical Examiner	23a. Part I. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	st,	Approximate Interval Between Onset and Death 5 years					
at the death certificate by the attending phy trached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	ac. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	ital death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
The law requires that the death certification has been signed by the attending phoage 2 should be detached for use as the	by P	Part II. Other significant conditions conf	ributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	1 🗆 Yes	: 2 <b>X</b> No 3 □ P	o the cause of death?  robably 4 □Unknown
(0	Completed						24a. Was an autopsy perform	prior to death? No 1 \( \text{Yes}	utopsy findings available completion of cause of
Phys this ral dii	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Menner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	28c. Injun Work	^{9r:} 4□ Nursing Ho	th (Check only one) ome 5 Residen 28d. Describe how	ice 6x Other (Spe	ocify) Asst. Liv
Hospital or Attending 24 hours after death. Funeral Director: After 1ely filled in by the fune.	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Town,		
To the Hospital within 24 hours a To the Funeral I completely tilled	Medicai		icien: To the best of my kier: On the basis of examinand manner stated.			oinion, death occur	red at the time, dat		e to the cause(s)
Z ¥ Z 8		<b>&gt;</b>	7	hiD,	D56			January 10	
aa s	State	30. Name and address of person who cor Harry Li, M.D. 8600 31. Date filed (Month, Day, Year)	Snowden Riv	ver Pkwy	7. Ste 30	1 Columbi	.a, MD 210	045	
Regis		JAN 1 1 20	108	1. 6	marke				

			For State	State of Maryl		artment of F			211	118	01833
		-11	Registrar  1. Decedent's Name (First, Middle, L	ast)	061	tineate or	Dealli	2. Date of De	Reg. No		3. Time of Death
К	Physic		Par		Snu	rlock		Month	Day	Year	
	/Medi		4a. Facility Name (If not institution, gr		<u>5pu</u>		r Location of Death	Januar	y /	2008	11:30 P ^M
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	Funeral				yrs. last birthday)	Freder If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthp	lace (State or Foreign
ь	Director		212-24-6531	¹XM 2□F 79	Yrs.	Months Days	Hours Min.	(Month, Da	y, <i>Year)</i> 0, 1928	Cour	ntry) cginia
ić			Usual Residence of Decedent					riay it	, 1720		gilla
	ylan how at		10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Mar a-f si	tor	Maryland Freder	ick	Thurmor	nt					1 X Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	alD	1 West Moser Ro	ad Apt. #9		217	88		United	State	3.5
	dear ems	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13. \		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Rac	ce - Americ	an Indian,
9	hours after tural", or ite		1 Never Married 2 Married	1 ∑Yes 2 No		I □ Yes 2 🗓 No	Specify:	nican, etc.)		ck, White,	
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Maryland 21215-0036	uld be fil Mental H rked oth	Be	17. Father's Name (First, Middle, Las				18. Mother's Name	e (First, Middle	, Maiden Surnar	ne)	
yla	ould Men arke	은		Spurlock				Jean	Seymour		
la _r	2 should be and Mental Is marked cramatic ev		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Numb	er, City or Town,	, State, Zip	Code)
2	ges 1 and 2 should be filed within 72 hc tt of Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Medical		Pauline Hall,	Friend					ourg, Ma		
ore	Jes 1 Fire		20a. Method of Disposition 1X Burial 2 □ Cremation 3 [		<ul> <li>b. Place of Disposition</li> <li>cemetery, cren</li> </ul>	sition (Name of natory or other plac	ce)	Date	20c. Location -	- City or To	wn, State
Ē	고 it e B		4 Donation 5 Dother (Spec		esthaven	Mem Gar	dens 01/	11/08	Frederi	ck.	Marvland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr		21. Signature of Funeral Service Lice	ngee	22	. Name and Addre	ss of Facility Sta	uffer F	uneral	Homes	. P.A.
_	82589		Klim &	1	10	4 East M	ain Stree	t Thur	mont, M	aryla	nd 21788
		1	23a art Enter the se in r cor shock, or head filure. Lift only	np cations that cause 1 1 d	leath. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	a. Due to (or as a con-		allen				_	4 days
E	Examiner			Preumo	oria						10 2000
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con:							io days
	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examine	Cause (Disease or injury that initiated events	. End Sta	o Lun	Disecc	e				Lyear
oʻ	execting an and rial-tr	Exa	resulting in death) Last	c. End Star Due to (or as a conf	sequence of):						ycoci
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မ	iffical g phy as th	edi									
Box	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre					23d. Da	ite of delive	erv
	deatl e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		Ectopic pregnancy Other (specify)	<u> </u>		Mo	onth	Day Year
P.0	that the de led by the a detached f	nys	9 ☐ Unknown	9□Unknown							
	w requires that s been signed to should be deta	y P	Part II. Other significant conditions	contributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use cont	tribute to th	e cause of death?
rds	quire: n sig	Completed by	COPD, CAD	Spinal Ster	osis Ch	ronic f	ain	1 🗆	Yes 2 No	3 ☐ Prob	ably 4 □Unknown
9	w rec	lete	, ,	· ·	,			24a, Was	an 24h	Were auto	psy findings available
Re	he la has ige 2	E C						autor	osy _	prior to cor death?	npletion of cause of
Vital Records,	n: T ficate or, pa		OF Man ages referred to medical	Ι				1 Yes	2 MNo		2 □ No
₹	Physician: this certificated director, partitions	Be	25. Was case referred to medical examiner?	Hospital:		Othe	_26. Place of Deatler:				
Division or	Phy r this ral di	٦.	1 Yes 2 → No  27. Manner of Death	1  Inpatient 2 28a. Date of Injury	2 ER/Outpatient	JU DON	4 □ Nursing Ho		dence 6 Oth		/)
on	dlng h. Afte fune	Certification:	1 Matural 5 ☐ Pending	(Month, Day Year	r) Injury	28c. Injun Work	k?¨ Yes 2∐No	Edd. Describe	now injury occur	ieu	
S	deat deat ctor: y the	ica	3 Suicide 6 Could not b		t home, farm, stre			28f Location /	Street and Numb	or or Pura	I Pauta Number
S	or A after Dire	Ħ	4 ☐ Homicide determined	28e. Place of injury - A building, etc. (Spe	ecify)	ot, idotory, office		City or To	vn, State)	er or mura	i Houte Number,
	purs ours eral filled		29a. Certifier 1 <b>Certifying P</b>	nysiclan: To the best of my	knowledge death	occurred at the tir	no date and place	and due to the	aguacía) and m		ente d
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	(Check only 2 Medical Exa	mîner: On the basis of exam and manner stated.	nination and/or inv	restigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
	orth orthin ompl	₩ M	29b. Signature and title of certifier	n/		29c. License	e number		29d. Date signe	d (Month,	Day, Year)
<b>)</b> .	->-0		1/1/11	1/2		N/	66610		01-1		•
	S	-	30. Name and address of person who	completed source of death it	tom 22a) (T 5				- 1	-	-0
2	XIII		. 1 1				Frede	-into	M	2.1	701
()\	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Si		21.55	,	-100,	, · · · · · ·		(
-	Registr		IAN 1 0	2008	KA	reals?					

08-00401	
Kenneth Spann	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death 4. Apple to Payard 4. Spann	h
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Suburban Hospital  4c. County of Death  Montgomery	
Funeral Director	5. Social Security Number 183-22-0436  6. Sex 1 7. Age (In yrs. last birthday) 183-22-0436  7. Age (In yrs. last birthday) 183-22-0436  7. Age (In yrs. last birthday) 183-22-0436  7. Age (In yrs. last birthday) 183-22-0436  7. Age (In yrs. last birthday) 184-185-185-185-185-185-185-185-185-185-185	
any	Usual Residence of Decedent  10a. State	/ Limits
. ₹	D.C. Washington	No
with the Maryland ns 23a or 28a-f sho he notified at once.		
er death	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 3 Widowed 4 Divorced of 1 Specify Yes of No- 1 Yes, Specify Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify:	k,
ours aft atural' xamine	Q	
36 thin 72 h ie. than "n edical E	15. Decedent's Education (Specify only highest grade completed)    Selementary/Secondary (0-12)   College (1-4 or 5+)     School Administrator   18. Middle, Last)   University of D. College (1-4 or 5+)     College (1-4 or 5+)   School Administrator   18. Middle, Maiden Surname)   19. Middle, Maiden Surname)	
21215-0036 Mald be filed within 7 Mental Hygiene, marked other than e event, the Medica	17. Father's Name (First, Middle, Last)  Edward Spann  18. Mother's Name (First, Middle, Maiden Surname)  Helena Rose Evans	
2121; Muld be fill Mental F. marked c event.	Edward Spann Helena Rose Evans  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
e, MD I and 2 sho Health and item 27 is	Annette Spann (Wife) 1501 Underwood St., N.W. Washington, DC 20012	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If iten 27 is marked other than 'injury or other traumatte event, the Medical	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Chesapeake Crematory  01/18/2008 Beltsville, Md.	
Balt permit Depart Impor Injury	21. Sign your of Funger Service Licensee Bacon CC36/32, Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, NW Washington, DC 20010	
Physician - /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Between One	set and
aminer	Immediate Cause (Final disease or condition resulting in death)  a Complications of Cervical Spinal Injection  Due to (or as a consequence of):	1
1	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	cause. Enter Underlying Cause (Disease or injury that initiated	
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760, icate be exe physician a the burial -	IF FEMALE:  23a,Pt.II,27,28a-f per ME g878 4/14/08 amh  23d. Date of delivery	
x 687 h certific ending p use as tl	12h Man decedent prognant in the	ear
P.O. BO; that the death ned by the att detached for thy Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of de	ath?
ords, P.O. w requires that the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the		known
ords  w requ as been should	Atherosclerotic Cardiovascular Disease; Fnd Stage Renal Disease  1  Yes 2 No 3 Probably 4 Un  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2	
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Vital I	25. Was case referred to medical examiner?  1 Ves 2 No  26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: Nursing Home 5 Residence 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should be artification: To Re Completed	27 Manner of Death 28a Date of Injury 28h Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
ision Attender death	Natural 5 Pending Investigation 2 X Accident	er, City
Div pital or ours after filled in	Suicide Could not be determined (Specify) Clinic or Town, State) 10810 Connecticut Avenue (Specify) Clinic	ve.
Division of To the Hospital or Attending Phe within 24 hours after death To the Funeral Director: After to completely filled in by the funeral Contification: To deaties!	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  January 15, 2008	
	30. Name and address of person who completed cause of death (Item 23a)	
R (2)	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra	18 N V V / (III) #2-1 M	

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Otato or mar	Cei	rtificate of		, 0	eg. No. 2 1 1 2	01835		
	Physici		1. Decedent's Name (First, Middle, Las	3 <i>t</i> )		2. Date of Death  Month  Day  Year  3. Time						
luc -	/Medic		Frances Hobl	os Spro	oles			January	6 2008	9:15 P ^M		
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deatl	h	4c. County of Dear	th		
	.ii		230 Gaylin Driv		In yrs. last birthday)	Brunsw If Under 1 Year		9 Date of Birth	Frede			
3	Funeral Director			□M 2FFF	\/	Months Days	Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign buntry)		
	when the case the		Usual Residence of Decedent		83 Yrs.			Jan. 16	, 1924 V1	rginia		
	yland yland at		10a. State 10b. County	1/	0c. City, Town or Lo	ocation				10d. Inside City Limits		
	Mar a-f st	ģ	Maryland Freder	ick	Bruns	wick				1 Tyes 2 □ No		
	or 28	ire	10e. Street and Number	-		10f. Zip Code		10	g. Citizen of What Co	ountry?		
	23a cust b	Funeral Director	230 Gaylin Driv	7e		21	758		United	States		
	r dea	ne	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit			
36	s afte	Ž.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:			hite		
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15, Decedent's Eq	Year or Dates:	16a Dece	dent's Usual Occup	astion	1.	16b. Kind of Business	Industry		
5	in 72 n "na ledic	olet	(Specify only highest gra	ide completed)	(Give	kind of work done DO NOT use retired	during most of world)	rking	TOD. KING OF DUSINESS	industry		
212	l withi jene. r than the M	E	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ales Cler			Departm	ment Store		
b	0 = 0 9	Be C	17. Father's Name (First, Middle, Last)		'		18. Mother's Nar	ne (First, Middle, M	faiden Surname)			
<u>la</u> r	should be id Mental marked o matic eve	To E	Ira Washington I	Hobbs			Ethe1	Lewis				
Maryland	s 1 and 2 should f Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)		
	1 and 2 Health em 27 l		Laura Fontaine /	Daughter	230 (	Gaylin Dr	ive Brun	swick, Ma	ryland 217	758		
ore			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, crei	sition (Name of matory or other plac	ce)	I	20c. Location - City or	Town, State		
Ē.	Pages ment of h ant: If Ite		4 □ Donation 5 □ Other (Specifi		Singers G		$ery_1 10$ .	uary _2008 S:	ingers Gle	n, Virginia		
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Femme   Service Licer	see	22	2. Name and Addre	ss of Facility St	auffer Fu	neral Home	es, P.A.		
	0 □ <u>=</u> a 0		7000	70						yland 21702		
Ι.,			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	e death. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death		
V	Physician		Immediate Cause (Final disease or condition resulting in death)		stitial L	ung Disea	.se			8 Years		
	/Medical Examiner		Tooding in county	Due to (or as a c	consequence of):							
		ē	Sequentially list conditions, if any leading to immediate	b. Due to (or as a c	onsequence of):							
115	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	,	. ,							
Ć,	exec n and ial-tra	Exa	resulting in death) Last	Due to (or as a c	consequence of):							
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	rtifica ng ph as th	Med	IF FEMALE:									
Вох	attendin for use	an/l	23b. Was decedent pregnant	23c. If yes, outcome pf   1□Live birth 2 [		Ectopic pregnancy	,		23d. Date of de			
	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at tim 9☐Unknown	ne of death 5	Other (specify)			Month	Day Year		
P.0	that the de ned by the a detached	Phy	Part II. Other significant conditions c	ontributing to death but s	not reculting in the u	ndarhijna sauca aiu	on in Bort I	22a Did tob	acco use contribute to	the eques of death?		
Vital Records,	signe signe	by	Taxin one organical contained	orange to death but in	iot resulting in the di	ndonying oddso giv	on an acti.			robably 4 Unknown		
Ö	w requir been si should	Completed								. –		
Rec	has has	ם						24a. Was an autopsy perform	y prior to	topsy findings available completion of cause of		
a								1  Yes 2	No 1 ☐ Yes	2 <b>⊠</b> No		
₹		Be	25. Was case referred to medical examiner?	Hospital:	0F1FD(0 t t)	oth Oth	Of:	ath (Check only one				
o	Phys r this eral dii	7: 70	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	IL SU DOA	4 LI Nursing H	lome 5 X Resider 28d. Describe hor	nce 6 Other (Spe	cify)		
ion	nding Ph th. ; After thi ? funeral	ţi	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	<i>(ear)</i> Injury		k? Yes 2∐No					
Division or	Attending r death. ector: After by the funer	lica	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (	- At home, farm, str	eet, factory, office		28f. Location (Str	eet and Number or R	ural Route Number,		
Ö	s afte	Certification;	Λ į	building, etc. (	эрвспу)			City or Town,	, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge, deatl	h occurred at the tir	me, date and place	e, and due to the ca	use(s) and manner as	s stated.		
	the H nin 24 the Fi	Medical	one)	and manner stated	d.			med at the time, da	are and place, and due	e to the cause(s)		
	To To	Σ	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)		
			MICHI			D60	167	J	anuary 7,	2008		
	b		30. Name and address of person who			•	4020	01-		1 20015		
	- 01-	10	Michael N. Solo	omon, MD 55	530 Wiscon	nsin Aven	ue #930	Cnevy Ch	ase, Maryl	and 20815		
	Sta	ıe	I BALL 1 0 2		H. O	CONS						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 3:20 P M John Taylor Jan 7, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3860 Sixes Road Prince Frederick Calvert 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**M 2□ F Director 218-12-8528 PA Dec 19, 1914 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director Prince Frederick MD Calvert 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 3860 Sixes Road 20678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be afy. 1 and 2 should be 1 Health and M Unknown Lillie Mae Henson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr. 1705 Adelina Road Prince Frederick, MD 20678 Earl Taylor /Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1⊠Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/12/08 Dunkirk, MD Southern Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gladys Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence or; Examine be executed use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ Ho 24a. Was an has page 2 autopsy Fullun perform certificate 2 1 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 10 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Hesidence 6 ☐Other (Specify) After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Maryland 21215-0036

Baltimore,

Box 68760.

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or Vital Records,

Division

State Registrar

Medical

4 Homicide

(Check only one)

31. Date filed (Month, Day)

29b. Signature and title of certifier

29a. Certifier

DHMH 17 Rev 1/2001

and manner stated.

Mathur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Prince Frederick, MD 20678

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

21215-0036

Baltimore,

Maryland **Physician** /Medical Examiner Certification: filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifler 29c. License number 29d, Date signed (Month, Day, Year) D0040519 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madison Park Dr. Glen Burnie, MD MNUSAIREC. 31. Date filed (Month, Day, Year) Agistrar's Signature JAN 0 9 2008 Registrar **ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physici /Medic		Frances Marie Trumpower  2. Date of Death January 13, 2008 3. Time of Death January 13, 2008 10:15 PM
	Examin		a. Facility Name (If not institution, give street and number)  Ravenwood Lutheran Village  Hagerstown  Washington
	Funeral Director		Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1
	a-f show	ctor	0a. State MD 10b. County Washington 10c. City, Town or Location Big Pool 10d. Inside City Limits 1□Yes 💯 No
	ath with the 23a or 28 ust by mo	Funeral Director	0e. Street and Number 10967 Big Pool Road 10f. Zip Code 21722 10g. Citizen of What Country? U.S.A.
980	be filed within 72 hours after death with the Maryland stal Hyglene. Id other than "natural", or Itams 23a or 28a-f show event, Ita Madical Examinational to Indifficed at	by	1. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  White Specify:
Maryland 21215-0036	d within 72 ha giene. ir than "natu ir e Madical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th grade 1 year  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) instructional assistant  16b. Kind of Business/Industry board of education
/land	2 should be filed and Mental Hygi Is markad othar raumatic event, II	To Be C	7. Father's Name (First, Middle, Last) Samuel A. Cain  18. Mother's Name (First, Middle, Maiden Sumame) Elsie M. Hart
	nd 2 sh lith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) son Denver H. Trumpower  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13002 Blairsvalley Rd.Clear Spring, MD 21722
altimore,	permit. Pages 1 al Department of Hea Important: If item any injury or otha once.	1	10a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Orchard Ridge Cem 2008  20c. Location - City or Town, State Hancock, MD
Bal	Depar Impor any ir		22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc  P.O. BOX 310 Clear Spring, MD 21722  23a. rgh). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate
	Physician /Medical		Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Dea
	Examiner	ier	Due to (or as a consequence of):  Sequentially list conditions, and, leading to immediate Due to (or as a consequence or):
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	al Examiner	cause (Disease or injury hat initiated events c. esulting in death) Last Due to (or as a consequence of):
9	ding physise as the l	/Medical	f FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
P.O. Box	that the death certific ed by the attending p detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 mopths? 1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year 9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unkno
	w requires that been signed to should be deta	ed by P	PARKINS ON'S, TYPERTENSION,  23e. Did tobacco use contribute to the cause of death?  1 Yes 3 No 3 Probably 4 Unknown
l Reco	The law no cate has be page 2 shi	Completed by	24a. Was an autopsy performed?  1 Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vita Vita	Physician: Th this certificate ral director, pag	Be	5. Was case referred to medical examiner? Hospital: Check only one)
l of	og Phys ter this neral di	n; To	1 Section 1 Inpatient 2 ER/Outpatient 3 DOA Uner 4 Nursing Home 5 Residence 6 Other (Specify)  7. Manner of Death 28a. Date of Injury (Month, Day Year) (Month, Day Year) Injury Work?
Division of Vital Records,	To the Hospital or Attending Physician: The Whitin 24 hours after death. White The Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	Natural   5   Pending investigation   2   Accident   3   Suicide   4   Homicide   4   Homicide   Suicide   Suicide   Accident   5   Pending investigation   M   1   Yes   2   No   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To tha Hospital or Within 24 hours afte To tha Funaral Dir completely filled in	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the	Me	9b. Signature and the of certifier  29c. License number  29d. Date signed (Month, Day, Year)  1/14/08
0	10		0. Name and address of person who completed cause of death (Item 23a) (Type, Print) 369 MILL STREET, MAGGESTOWN, MP 21740
:	Sta Registra		369 MILL STPEET, MAGGESTOWN, MD 21740  11. Date filed (Month, Day, Year)  JAN 1 6 2008  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 01839 Amended item#9 01.16.08,slu Certificate of Death

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be ilied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Apportant: if item 27 is marked other then "naturel", or Iteme 23s or 28s-f show hy injury or other traumatic event, it a Madical Exeminar must be notified at Baltimore, Maryland 21215-0036

/Medical

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician Examiner within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, Last)	)		2. Date of Death Month Day						
in al	Mildred E.	Thomas		01 0		0538AM				
er	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deal	th	4c. County of Death					
Щ		ursing LLC	Salisbury, 1	ND I	WICOMIC					
	5. Social Security Number 6. Set	X ZAge (In yrs. last birthday) M 2DF 65 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Yes	9. Birthp	lace (State or Foreign stry)				
	Usual Residence of Decedent	63		07/22/19	93 Geo	rgia				
	10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits					
ţo	Md Wicom	ico Solist	IDY			1) Yes 2□No				
rec	10e. Street and Number	100 041130	10f. Zip Code	10g. (	Citizen of What Coun	itry?				
To Be Compieted by Funerai Director	CIVIC	, AVENUE	21801	(	1 SA					
ner	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ					
Ē	1 Never Married 2 Married	1 □ Yes 2 NV No	_ \	to Hican, etc.)	Black, White,	etc.				
d b	3 ☐ Widowed 4 Divorced	Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	HCK				
etec	15. Decedent's Edu (Specify only highest grade	cation 16a. Decede completed) (Give	dent's Usual Occupation kind of work done during most of wo	nkina 16b.	Kind of Business/Inc	`				
mρ	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		Cont	tgra				
ပိ	17 Salbada Nama (Sinot Middle I and)	1740	Ker/Labore		Fouchs	0				
Be	17. Father's Name (First, Middle, Last)	Davis		me (First, Middle, Maid	en Sumamer	-01/6 - 1				
ဠ	JETTERSON	,	- Carri		1 161	erson				
	19a. Informant's Name/Relationship (Ty	- (1. 11) 15	ng Address (Street and Number or R. .081 Utica 1			19950				
	20a. Method of Disposition	S (claughter) 2			Location - City or To	<u> </u>				
	1 Burial 2 ☐ Cremation 3 ☐ R	temoval from State cemetery, crer	matory or other place)	1	as friend	D a				
		Middlefo	R. Name and Address of Facility, BENNIE Smith FUNERAL HO		Caturai	De d				
	IM h was	me = J	W. Isabel Hisbury	nd 21801						
	23a. Part1. Inter the disease, or compli	cations that caused the death. Do not ent	er the mode of dying, such as cardia	c or respiratory arrest,	,	Approximate Interval Between				
	Immediate Cau e (Finat disease or condition	4 1.	Car Tovasular			Onset and Death				
	resulting in eath)	Due to (or as a consequence of):	Cor o 10 vasay ar	circia.						
	Commission									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
am	Cause (Disease or injury that initiated events									
an/Medicai Examiner	resulting in death) Last	Due to (or as a consequence of):								
dica		J								
Me	IF FEMALE:	0-16								
an	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ry Day Year				
/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)			,				
Completed by Physi		ntributing to death but not resulting in the ur	nderbing cause given in Part I	23e Did tobacc	o use contribute to th	e cause of death?				
٥	Caurnary	overy disus		1 ☐ Yes		ably 4 Dunknown				
ete	Dia	7 01201								
E E	7001.			24a. Was an autopsy	24b. Were autop prior to cor	osy findings available aptetion of cause of				
o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	104	ath Check only one	• 🗆					
- 1	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury 28b. Time of	T SE DOA 4 Mulsing F	fome 5 ☐ Residence		)				
ě	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,					
g ⊒	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre	eet, factory, office	28f. Location (Street	and Number or Rura	l Route Number,				
er.	4 Homicide	building, etc. (Specify)		City or Town, Sta	are)					
edical Certification;	Check only 2 Medical Examin	sicien: To the best of my knowledge, death ner: On the basis of examination and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occu	a, and due to the cause urred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)				
Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number			Table 1				
	, ,	ule up	3 3 2 5/4		29d. Date signed (Month, Day, Year)					
					1/9/08					
	30. Name and address of person who com  MAHE'S H MOVN'S	mpleted cause of death (Item 23a) (Type, IEA W) 106 MI)	Print)  PROVASA SON B	. Salibuo	ny Mo à	1804.				

State

Registrar

JAN 1.0 2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

0

08-00464 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ricky Scott Wilkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 16, 2008 **Medical Examiner** RICKY SCOTT WILKINS 1931 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Civista Medical Center La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex Months Davs Min Hours Director 187-42-8922 1 XM 2 F 55 Country) 11-03-1952 PA. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show MARYLAND CHARLES 1 Yes 2 X No HUGHESVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12505 GROSSTOWN ROAD 20637 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. Never Married 2 X Married Yes XΝο after Yes, Give Year Widowed Divorced Yes 2X No specify: Specify: WHITE "natural" ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Tant: If item 27 is marked other than or other traumatic event, the Medica 9th SALES ASSOCIATE WAL-MART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT McKINLEY WILKINS, SR. Be MARION JUNE RUMMEL 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD PEGGY WILKINS-SPOUSE 109 MAIN STREET ACOSTA, PA. 15520 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
HUSBAND CEMETERY 1 XBurial 2 Cremation 3 Removal from State Department o 1-25-08 SOMERSET, PA. Donation 5 Other Specify: 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility 23a. Part I. Enter the disease, or complication) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical Death a Hypertensive atherosclerotic cardiovascular discusse Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED #23a,27 perME,g876, attending physician or use as the burial Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) detached for 1 Yes 2 No 9 Unknown Q Unknown Part II. Other significant conditions Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 certificate No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) uneral director, of Vital Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 this DOA Nursing Home 5 Residence 6 Other 2 1 Yes No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Division Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director:
completely filled in by the f

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day Year)

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 17, 2008

			Plea	se Type or P	rint in B	Black Ind	delible Ink.	Ensu	ıre Al	I Copies	s Are	Legible.		
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>		10	Registrar     Decedent's Name (First, Middle)	, Last)	-					2. Date of D	eath	200	3. Time of I	Death
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			Levinda 5. Social Security Number	le Hebrew Cent	er Age (In vrs. I	loot hirthday)	If Under 1 Year	Baltim If Under		8. Date of Bi	irth	a Bi	rthplace (State or	Foreign
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	Maryland -f show lied at	tor	10a. State 10b. County		10c. City	, Town or Lo	cation	Baltin	nore				10d. Inside City	
	th the	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of What C	Country?	
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	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Ori an, Mexicar	igin? (Spo n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh		
0000	ural", or i	2	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give Year or Date			Yes 2 No	Specify:			1 401	Specify: BI		
-017	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  I of Health and Mental Hygiene.  I where 271s marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	durina mos		ing	160.1	Kind of Busines	Schools	
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2	Pages 1 nent of H int: If Iter iry or oth		20a. Method of Disposition 1 ♣Burial 2 ☐ Cremation	3 □Removal from St		lace of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence of Disportence o	sition (Name of natory or other plac	ce)	ι	Date	20c. L	Location - City o	or Town, State	
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	^	i	30. Name and address of person	who combleted cause	of death (Item	1 23a) (Tvne.	Print)	116	0	10 1	1	1112	0	_
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08-00457 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jessica Lynn Watkins State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Rea. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month Day January 16, 2008 Medical Examiner Year Jessica Lynn Watkins 1552 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5629 Columbia Road Apartment 304 Columbia Howard **Funeral** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Foreign Maryland Country) Hours 218-13-0032 M 2 X F 21 April 24,1986 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Columbia 1 X Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5629 Columbia Road, Apt. 304 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces 1 X Never Married 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes Widowed 4 Divorced If Yes, Give Year White Yes 2 X No specify: à Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 I
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "r
injury or other traumatic event, the Medical E Blockbuster Video College (1-4 or 5+ Baltimore, MD 21215-0036 Twelve Years Shift Leader Columbia, Maryland 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Thomas R. Watkins Joanne Doelle 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas R. Watkins (Father) Samuel Chase Drive, Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State crematory or other place) R.A. Ferris & Co., Inc. 01/19/08 West Chester, Pennsylvania Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Physician 23a. Part I. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva failure. List only one cause on each line. /Medical Between Onset and Immediate Cause (Final disease a Diabetic ketoacidosis Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED AMENDED #23a,27, perME, g875, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 V Fetal death past 12 months? Month Day

requires that the death certificate be executed attending physician or use as the burial Box 68760. signed by the atte P.O. 1 Records, s certificate has been si rector, page 2 should b Hospital or Attending Physician: Division of Vital this c After after death.

⋧ Completed Be Certification; Director: d in by the f Funeral D within 24 hours Medical

1 Yes 2 No 9 Unknown

29b. Signature and title of certifier

Mis

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 2 1 1 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 V Yes Nursing Home 5 Residence 6 V Other: Scene 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

To the

31. Date filed (Month Day, Year) 2 32. Registrar's Signature

and manner stated

q

29d. Date signed (Month, Day, Year)

January 17, 2008

Death

Year

Pregnant at time of death

Unknown

5

08-00465 Valerie Walter

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

alerie vvallei		1- For State Certificate of Death	and Mental n		. No. 200	18 0184
Physici	an/		···	Date of Death     Month	Day Year	3. Time of Death
ledical Exam		valerie L. warter	n, or Location of Death	January 16	, 2008 4c. County of Death	1856 hrs
		10230 Keysville Road Emmitsl		1	Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1			(MM/DD/YYYY) 9. Bir	
Director		187-52-4886 1 M 2 X F 48 Yrs. Months	Days Hours Min	Jan. 3,	1960 ^{Co}	^{untry)} Texas
апу		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d How at						1 Yes 2 X No
arylan  8a-f sl		Maryland     Frederick     Emmitsburg       10e. Street and Number     10f. Zip ∞	ode	10	g. Citizen of What Cou	ntry?
11458 death with the Maryland or items 23a or 28a-f show must be notified at once.			21727		United	States
th with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
ter dea			No specify:		Specify: W	hite
215-0036 be filed within 72 hours after natal Hygiene red other than "matural", elect other than "matural", ithe Medical Examiner.	d by	Jor Dates:			16b. Kind of Business/	Industry
2 3 T	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		iireu)		
-003 I withii giene her th	J W	2 Homemak 17. Father's Name (First, Middle, Last)		e (First, Middle, M	Own Ho: aiden Surname)	me
21215-0036 Juld be filed within 72 h martal Hygiene marked other than "n ic event, the Medical E.	Be C			Jean Lam		
5 2 9 E 6		19a. Informant's Name/Relationship (Type, Print )				22410
and 2 shour lealth and N tem 27 is n traumatic		Marie Walter / Daughter 3512 Minika 20a. Method of Disposition 20b. Place of Disposition (Name		pt 21, S	t. Louis P	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	Jar	nuary	Enodonials	Maruland
Baltimore permit. Pages 1 Department of 1 Important: If injury or other		4 Donation 5 Other Specify: Stauffer Cremat 21. Signature of Funeral Service Licensee 22. Name and Ac		, 2008 auffer Fi	Frederick, uneral Home	
Berr Perr Dep Tinju	9 30	104 E. M	Main Street	Thurmo	nt, Maryla	nd 21788
Physician /Medical		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of callure. List only one cause on each line.	dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
aminer	0.0	Immediate Cause (Final disease or condition resulting in death)  a. Dilated cardoimyopathy  Due to (or as a consequence of):				Deatil
	١. ا	Sequentially list conditions, b.				
	Examiner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed sit	l a	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
OX 68760, cath certificate be executed attending physician and for use as the burial - transit.	cal	d.  X UNPENDED  AMFINER - 2/28/08 TT				
60, ate be ohysicie	Medical	WINPENDED #25a,27, perME, g876, 2/28/08 TT  If FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	ry
687 certific nding p	jan/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specific	3 Ectopic pregr	nancy	Month	Day Year
Box death he atter d for u	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	//			V
D.O. B that the d ned by the detached	احا		ause given in Part I.		bacco use contribute to	the cause of death?
cords, P law requires the has been signals 2 should be d				Yes		utopsy findings available
COFC Law re-	Completed			autop: perfor	sy prior to med? death?	completion of cause of
Re i: The ificate i, page	5		.Place of Death (Checl	1 Yes	2 No 1 🗸 Y	es 2 No
Vital Rec ysician: The his certificate director, page	o Be	examiner? Hospital:	Other:		Residence 6 🗸 Othe	er: Scene
n of \ding Phy After tl	n: To		ic. Injury at Work?	28d. Describe h	now injury occurred	
Sion Attendideath.	atio	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	20f Location /6	Street and Mumber of D	tural Route Number, City
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)	mice building, etc.	or Town, S		tural Route Number, City
Hospit 24 hour Funer tely fill		29a, Certifier	me, date and place, ar	nd due to the caus	e(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my o and manner stated.	ppinion, death occurred	at the time, date	and place, and due to t	he cause(s)
	Σ		License number  O.C.M.E.		January 17, 200	
		30. Name and address of person who completed cause of death (Item 23a)			January 17, 200	
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 21	201		
	tate	e 31. Date filed (Month, Day, Year)  AN 2 2 2008  32. Figistrar's Signature				
Regis						<u> </u>
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			For State	State of M		epartmen <i>Certificat</i>				lental Hy		00.	0.0	0.1.01.6
	_		Registrar  1. Decedent's Name (First, Middle, La	ist)		Certificat	e or i	Dealli		2. Date of D	Reg. No	20	U U	3. Time of Death
	Physici		T. Doodgont o Harro (Finos, Imagio) La	John H. W	loods					Month Januar	Da		Year 008	12:05a
14	/Medi Examir		4a. Facility Name (If not institution, given			4b. City,	Town, or	Location	of Death	Januar			of Death	
7			3697 Ridgeview Ro	ad			Ιį	amsvi	ille			Fr	eder	ick
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ge (In yrs. last bir	Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Year,</i>		9. Birth Cou	place (State or Foreig
	Director		213-40-5268 Usual Residence of Decedent	TAJIVI ZLI	64	Yrs.				April	10,1	943	Was	hington, D
	land ow t		10a. State 10b. County		10c. City, Towr	or Location								10d. Inside City Limits
	Mary Fish	to	Maryland Freder	ick	Tian	sville								1 ☐ Yes 2 🗵 No
	h the r 28a r noti	Director	10e. Street and Number	ICK		10f. Zip	Code				10g. Ci	tizen of V	What Cou	intry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	al D	3697 Ridgeview	Road			21	754			U	nite	d Sta	ates
	r dea tems er mu	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	13. Was Dece If Yes, spe	dent of H	ispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	0-		e - Ameri k, White	can Indian, , etc.
36	s afte	y F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐	No 1960-63	1 ☐ Yes	2 <b>½</b> No	Specify.	:			Specify	· Wh:	ite
Ö	hour Itural	Completed by	15. Decedent's E	1		Decedent's Usu	al Occup	ation			16b. K	and of Bu	usiness/lr	ndustry
15	in 72 n "na n dedic	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or		(Give kind of wo	ork done i se retired	during mos t)	st of work	ing				,
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pu	al Hy I othe vent,	Be	17. Father's Name (First, Middle, Las	1)				18. Moth	er's Nam	e (First, Middle	e, Maider	Surnan	ne)	
yla	2 should be filed w n and Menta! Hygie Is marked other tl raumatic event, th	户	Edward Wood							r Flet				
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Menta! Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship			Mailing Address								
	1 and 2 Health tem 27 I	9	Patricia A. Woo	ds / Wife		97 Ridv				jamsvi. _{Date}				1 21754 Town, State
Baltimore,	Pages nent of Runt: If ite		1 ☐ Burial 2 🖾 Cremation 3 [		·	Disposition (Narry, crematory or o		1.	Janu	ary			•	·
Ħ	+: E 29 :=		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		Stauff	er Crema	atory	7 ss of Facili	11,	2008	Func	deri	Lck,	Marylands, P.A.
Ba	Depar Impor any Ir		) VQ	26		1								land 21771
	10 Vi de		23a. Part1. Enter the disease or conshock, or heart failure. List only	plications that cause	d the death. Do r								- í	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	one cause on each	VN AR	DIA	150	Indian	lica					Onset and Death
Ĵ.	/Medical		resulting in death)	Due to (or as	a consequence	of):	100	<u>nem</u>	1000					<i>L</i>
b.	Examiner		Sequentially list conditions.	b. Me	tastatio	Blade	ler	cav	rer					marth.
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):								
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9	ificate g phys as the	edic												
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	deat e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a		3 ∐Ectopic p 5 ∐ Other (s _i						Mo	nth	Day Year
P.0	that the de ned by the detached	Physician/Me	9 Unknown			40.000				00- Pid			(-11 · 4 · 4 ·	
	es gr	b	Part II. Other significant conditions	contributing to death t	out not resulting in	the underlying o	ause giv	en in Part	I.			use cont	3 ☐ Pro	the cause of death?
or Vital Records,	w requir	Completed					<del></del>							
360	has be 2 s	ם									s an opsy formed ∕∕		Were aut prior to co death?	opsy findings available ompletion of cause of
<u></u>			25. Was case referred to medical	T				A0 D1		1□ Yes	2 <b>☑</b> N		1 □ Yes	2□ No
Ξ	Physician: The this certificate har all director, page	o Be	examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2□FR/Qu	tpatient 3 □ D0	Oth	or.	ursing Ho	th (Check only		e □Oth	ner (Spec	i6 ₄ )
0	<b>₽</b> = ₽	n: To	27. Manner of Death	28a. Date of Inju	ury 28b. 1		28c. Injur Wor		draing ric	28d. Describe				,
joi	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	n	ly rear)	М		Yes 2□	No No					
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	o the	Mec	29b. Signature and title of certifier	and marrier si		29	c. Licens	e number			29d. Da	ate signe	d (Month	, Day, Year)
	X		► \$171Ahaam	A.7 H	EGAZI	[ CIMI	)4	416	4		1 -	10.	_2008	8
_	All.		30. Name and address of person who	completed cause of	death (Item 23a) (	Type, Print)			•		•			
3	O,		A. Zakaria Hega				on I	rive	F	rederic	k, M	lary1	and	21702
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1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours a Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu and title of certifier D0060417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Thomas men 6S C Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 4 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Reg. No.- U Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician January 9, 2008 2:49 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Health Care Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Director 578-16-1120 86 Washington D.C Aug. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be provided. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3232 Bidle Road 21769 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 Armed Forces? 1 Armed Forces? 1 Provided Forces 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by Specify 3 XWidowed 4 ☐ Divorced Year or Dates: WWII White 16a. Decedent's Usual Occupation . 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Office C & P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles J. Weeks <u>Barbara Cooper</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Kostreski/ Daughter 3232 Bidle Road, Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory Inc 1/10/2008 Frederick, Maryland 22. Name and Address of Facility
Stauffer Funeral Home P. A. 21. Signature Juneral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final COLON **Physician** conce disease or condition resulting in death) /Medical Due to (or as a consequence of) shilloutive pulminary disease Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this control. physician and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical director, 26. Place o eath Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) 19/68 D 8062223 " 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Proveen

31. Date filed (Month, Day,

Bolarun

2008

Year)

**JAN 1 0** 

MD 196 TJ Drave

Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JAN 14

2008

08-00255 Clifford West Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1- For State Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) 0448 hrs January 9, 2008 Physician/ West Jr. xaminer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury Peninsula Regional Medical Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number Min Country) MD Hours **Funeral** Months Days 1929 Feb. 7, 78 Director 1 X M 2 F 220-26-1514 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 Yes 2 X No 10b. County 10a. State Salisbury 28a-f show Wicomico 10g. Citizen of What Country' notified at once. MD with the Maryland Director 10f. Zip Code 10e. Street and Number USA 21804 30590 Bennett Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral must be Armed Forces? 1 Never Married 2 X Married hours after death 2 X No 1 Yes White Specify: Yes 2 X No specify: 4 Divorced If Yes, Give Year 3 Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done þ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed permit. Pages 1 and 2 should be filed within 72 ho. Department of Health and Mental Hygiene. Important: If item 27 is marken. College (1-4 or 5+) Elementary/Secondary (0-12) Poultry Poultry Truck Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Taylor Edith Sr. West Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30590 Bennett Road Salisbury, MD 21804 Dorothy West- Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Hebron, Maryland 1/14/2008 Springhill Memory Ga. Donation 5 Other Specify. 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Salisbury, MD 21804 705 E Main Street Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician Death failure. List only one cause on each line edical Contact Gunshot Wound of Head Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): executed and trans Physician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of deliver 23c. If yes, outcome of pregnancy Records, P.O. Box 68760, Year IF FEMALE: 23b. Was decedent pregnant in the Day Month 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the atte Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 🗸 Unknown ò 24b. Were autopsy findings available 24a. Was an Completed prior to completion of cause of certificate has been s ector, page 2 should l autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 26.Place of Death (Check only one) he Hospital or Attending Physician: The in 24 hours after death. The Funeral Director: After this certifica pletely filled in by the funeral director, pa 25. Was case referred to medical Nursing Home 5 Residence 6 Other₄ Division of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 28d. Describe how injury occurred 1 V Yes မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Jan 5, 2008 28b. Time of Injury Subject shot self 27. Manner of Death Yes 2 ✔ No 1700 hrs Certification: Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) Forrest Plains Road, Salisbury, MD 3 🗸 Suicide 6 Could not be (Specify) Local Street determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Homicide 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** January 10, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. trar's Signature 2008 32. Reg 31. Date filed (Month 14) Year State Registrar

ORIGINAL

08-00413 Justin Woods Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ustin Woods		State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Registrar  Registrar							
Physicia	n/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  ONLE I							
Medical Examir		Justin Woods  January 14, 2008  2045 nrs  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death							
		5007 Megan Drive Clinton Prince George's							
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Director		258-53-5481 1x M 2 F 22 Yrs. Months Days Hours Min. April 7.1985 Aftlanta, Ga.							
	<b>+</b>	Usual Residence of Decedent							
v any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Prince Georges Clinton 1  Xes 2 No							
land Shov									
Mary Mary	rec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
with the Maryland ns 23a or 28a-f sho		5007 Megan Dr. 20735 United States  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							
ath wi	Funeral Director	1 Never Married 2 Married Armed Forces?  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  White, etc.							
her de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Black							
hours af	핡	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							
6 172 ho cal Es	ete	Elementary/Secondary (0-12) College (1-4 or 5+) Student Fducation							
withir riene.	Completed	12 2							
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'r	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Todd LaRoyce Woods  Merria Alcyna Winston							
212 uld be Menti mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. item 27 is marked other than r traumatic event, the Medica	7	Todd LaRoyce Woods/ Father 5007 Megan Dr. Clinton, Md. 20747							
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)							
Pages nent of		Metropolitan 1/19/2008 Alexandria, Va.							
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra	ı	21. Signature of Funeral Servi Licensee  22. Name and Address of Facility  Alexander S. Pone P.A.							
		23a. Part 1 Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interver							
Physician /Medical		failure. List only one cause on each line.							
aminer		Immediate Cause (Final disease or condition resulting in death)  Sudden unexplained death in epilepsy  Due to (or as a consequence of):							
		Sequentially list conditions,  b.							
	ner	if any, leading to immediate Due to (or as a consequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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50, te be executed sysician and burial - transit	Medical	X UNPENDED #23,27, perME, g876, 02/11/08 TT							
Box 68760, e death certificate be the attending physic ed for use as the bur.	Š į	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery							
30x 6876 leath certificate e attending phy for use as the	Physician/IV	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Fear							
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S, P.C luires that in signed	edk	24a, Was an 24b. Were autopsy findings availab							
ord aw req as bee	ompleted	autopsy prior to completion of cause of performed? death?							
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cian:	Be (	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Scene							
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	٤	1 Ves 2 No location 1 location 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
nding nding th. : Afte	ion:	1 X Natural 5 Pending (Month, Day, Year)  1 Yes 2 No							
isic Atter er dea rector	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural								
Division of Vital Records, pital or Attending Physician: The law requirers after death.  neral Director: After this certificate has been iffled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify) or Town, State)							
Hosp 24 hou Fune stely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
FFFO	ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							
		O.C.M.E. January 15, 2008							
- 0		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	ate								
Regis	ate rar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21, 2008 4c. County of Death 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 ☐ M 2 🗹 F Months 214-22-563 Usual Residence of Decedent Director North Carolina 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ke 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location -1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatur e of Funeral Service Licensee 23a. Part ... Inter the dissance of condition resulting in death) Inter the distance, or complically his that distance sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician rest /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 211 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 02. 2 10 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier f Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D37343 address of person who completed cause of death (Item 23a) (Type, Print) BANTIMORE MD ZIZIS 2600 CIBERTY HEIGHTS AVE.

State Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend 19b, 20b, perFH, g875, 1/28/08 TT Certificate of Death

Reg. No. Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** Milchel 8:00 AM JANUARY BERMAN 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITA Mucotallabury. BALTIMORE Northwest 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 213-76-9155 Director 47 MDUsual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h. County 10a. State iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MDBALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 47 CHASE MILL CIRCLE 21117 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANAGER MEDIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be IRVIN BENNETT BERMAN VIVIAN COHEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21208
25 THOMAS CRADDOCK COURT, OWINGS MILLS, MD 21111 19a. Informant's Name/Relationship (Type. Print) MARK BERMAN / BROTHER 20b. Place of Disposition (Name of cemetery, crewatory or other place)
HEBREW YOUN MENS 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/25/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) blas IOMA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause that underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes 25 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical ( 29a. Certifier tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0054558 hysiciAN on who completed cause of death (Item 23a) (Type, Print) and address of per Old Court Road RANDALISTOWN, MO CEDERIN Bur Ke, JR, MO 5401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 8 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 7:40 A HELIV LOWY JANUARY 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MANOR CARE RUXTON RALTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 KF Days 220-24-4191 94 Director -5-12 MANJAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 No Frederic Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Loursey Station Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. er than "natural", or iten the Medical Examiner 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HouseKeeper permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ncistian ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Russell Brown 4317 Elderon Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Arbutus 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 119-121 5.5tm LRO-ST 23a. Part1. Enter the dise lise, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BAITO, MD 21223 Immediate Cause (Final CORONARY Physician ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Doknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No death. 2 ☐ Accident To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P57722 JANUARY 23 2008 M.D. LEUNARD RICHARDSON M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PAILESVILLE MD

GPAD # 300

32. Registrar's Signature

GREENE

31. Date filed (Month, Day, Year)

TREE

DHMH 17 Rev 1/2001

State Registrar

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									T			
Physici	an	1. Decedent's Name	•	2. Date of De	ath Day	Year	3. Time of Death					
/Medic		RAREN MARIE BERG								23	2608	11:14 PM
Examin		4a. Facility Name (II	f not institution, give	4b. City, Town, o	r Location of Death		4c. Cour	nty of Death				
		HOWARF	) Cour	Ty GEN	HOSPIT	PL-	(OLU	WBIA.		H	DW AH	RD
Funeral		5. Social Security N			(In yrs. lasi		If Under 1 Year		8. Date of Birt	h	9. Birth	olace (State or Foreign
Director		472 50 0	01.47	□ M 2 <b>X</b> F	<b>C</b> 2	Yrs.	Months Days	Hours Min.	(Month, Da		Couir	ntry)
Director		473-50-8 Usual Residence of			_62			į.	Oct.26,	1945		Georgia
and and		10a. State	10b. County		10c. City, T	own or Loc	ation	· · ·			1	10d. Inside City Limits
sho	5	Maryland	Howard						1 □ Yes 2 <b>X</b> □ No			
Ba-i	ect				<u>α</u>	olumbi	T					
or or	Director	10e. Street and Nur				10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
ath w 23a ust I	- E	6144 Lla	ınfair Dri	ive		21044				USA		
ems erm	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. V	as Decedent of F	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		Race - Americ Black, White,	
after or it		1 Never Marri	ied 2 <b>X</b> Married	1 ☐ Yes 2 ☐ XV If Yes, Give	lo		☐ Yes 2 XNo	Specify:				
al",	by	3 ☐ Widowed	4 Divorced	Year or Dates:		'	Lifes ZLANO	эреспу.		Spe	cify: Wh	ite
2 hc	Be Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry										
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with iene iene tha		Elementary/Seco	(U-12)	5+	·	Hoalt	h Caro E	xecutive		Admin	istrat	tive
filed Hyg ther	Q	17. Father's Name (	(First, Middle, Last)			TICALL	II Care I	18. Mother's Nan	ne (First, Middle,	Maiden Surn	iame)	
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nould I Me nark natio	유		Johnson	5 - 0 : 11					Goplen			
2 st and is n			ame/Relationship (7					and Number or Ru		•		•
and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at		Gene A.		Husband				Drive, (				
of H		20a. Method of Disp		Romoval from State	20b. Plac cem	e of Dispos etery, crem	ition (Name of atory or other pla	ce)	Date	20c. Locatio	n - City or To	own, State
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permit. Departr Imports any inj		D MA	hone >	ZOCI	W0128	33 23	tzke Fun 55 Twin	ess of Facility Deral Home Knolls Ro	e, Inc.	ımbiə	MD 21	1045
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		shock, or hea										Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)		u			COPE	IN CA	NUCR			
Examiner		,		Due to (or as a	a consequen	ice of):	(-0-	-00.10-		*/ 0		11011-20
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ath certificate be executed trending physician and for use as the burial-transit	ian/Medical		•	d								
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h cel	Z	IF FEMALE: 23b. Was decedent	t pregnant				23d. I	Date of delive	ery			
deat a atte	Cia	in the past 12	months?	4☐Pregnant at			Ectopic pregnancy Other (specify) _	у			Month	Day Year
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that ed b deta	<u>a</u>	Part II. Other signif	lcant conditions co	ontributing to death bu	it not resultin	ng in the un	derlying cause giv	en in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of death?		
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requipon	Completed											
law as b	현								24a. Was autor	osy	<ul> <li>b. Were auto prior to co</li> </ul>	opsy findings available on mpletion of cause of
The ate I	ő								perfo 1□ Yes	rmed? 2.X.No	death? 1 ☐ Yes	2 No
ilan: ertific ctor,	Be (	25. Was case referrexaminer?	red to medical					26. Place of Dea	th (Check only o	ne)		
ding Physician: The lav n. After this certificate has funeral director, page 2 3	10E	1 ☐ Yes 2	No	Hospital: 1 Inpatier	nt 2 ER	/Outpatient	3□ DOA Oth	ier: 4 ☐ Nursing H	ome 5 ☐ Resid	dence 6 □0	Other (Specil	fv)
g Pt ter th		27. Manner of Death		28a. Date of Injur (Month, Day		Bb. Time of Injury	28c. Injui Wor	ry at	28d. Describe h	now injury occ	urred	
ndin tth. r: Aff	tio	1 X Natural 2 ☐ Accident	5 ☐ Pending investigation	(WOIRI, Day	(Car)	Hijury		Yes 2 □ No				
Atte r deg ecto by th	fice	3 ☐ Suicide	6 ☐ Could not be determined	Zoe. Flace of Inju	ry - At home	, farm, stre	et, factory, office				mber or Run	al Route Number,
To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to	Certification:	4 ☐ Homicide		building, etc	. (эреспу)				City or Tov	vri, State)		
hours inera y fille		29a. Certifier	1 Certifying Phy	ysician: To the best o	f my knowle	dge, death	occurred at the ti	me, date and place	, and due to the	cause(s) and	manner as s	stated.
To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical	(Check only one)	✓ I Medical Exam	iner: On the basis of and manner state	examination ted.	and/or inv	estigation, in my o	opinion, death occu	rred at the time,	date and plac	e, and due to	o the cause(s)
To tl	Σ	29b. Signature and	title of certifier				29c. Licens	se number		29d. Date sig	ned (Month,	Day, Year)
			1	- ou	()		DOC	59649	ĵ	JAN	72	5 7.00 8
11	-	30. Name and addre	ess of person who d	completed cause of de	eath (Item 23	Ba) (Type, F	Print)		1	- 111		2
50		IKECI			MBO		M.D	. 575	5 CEDI	AR LA	NE CO	5 2008 imBIA m24

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Division or Vital Records, P.O. Box 68760,

LKECHUKWU 31. Date filed (Month, Day, Year) State

8 2008

D 2. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Katherine Agnes Bittner **Physician** 3:05 3008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore Rosedail Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, March 10, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 85 1 ☐ M 2**/X**F Maryland 217-14-0181 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show be notified at Maryland Baltimore Baltimore 1 ☐ Yes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21234 USA 9809 Hilltop Drive permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Eximiner must Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own_Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle Coffenberger Laurence G. Rebhan ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9811 Hilltop Drive Baltimore Maryland <u>Steven Blaha /Godson</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 1/30/08 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 prestin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sizast Physician /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Litter or usering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Aspiration Pheumonia Due to (or as a consequence of): physician s the burial P.O. Box 68760 death certificate be Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atrical COPD 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the telety filled in by the funera 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records,

within 24 hours a To the Funeral L

State Registrar

DHMH 17 Rev 1/2001

rumps Ensur 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

and manner stated.

9000 Franklin Square Drive Baltmore MD egistrar's Signature

Sor

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9, 2008 4:45 AM Frank N. Brightwell January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Hyattsville Prince George's Hyattsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 22, 19 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☑ M 2 ☐ F 90 Director 579-09-8084 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he any ifficult 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Director Hyattsville MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20782 3931 Nicholson Street USA Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14 Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: black Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16h Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lunk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6500 Riggs Road Hyattsville, MD Manor Care Hyattsville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 M Other (Specify) celicensee S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C e (Final disease or con lion resulting in death) ALZEINERS DEMENTIA **Physician** Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 1 Yes 2 No Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ð RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably d ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 this 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 (Month, Day Year) the Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIFATPUH 6711 Source Ave Priverdake My societ 200 SURESH KUMAR 31. Date filed (Month, Day, Year)

JAN 2 8 2008 3. Registrar's Signature State Registrar

Physicia /Medica Examine	al
Funeral Director	
yland	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Many Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or items 23a or 28e-f ehk eny Injury or other freumatic event, the Medical Examplian must be notified a once.

Baltimore, Maryland 21215-0036

Priysician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	For State Of Marytan	•	rtificate of L			eg. No.					
	Decedent's Name (First, Middle, Last)				2. Date of Dea		· · · · ·	3. Time of Death			
ın	William H. Berry				January	15, 20	$08^{\text{Year}}$	5:15 AM M			
al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death				
	Ginger Cove Health Center		Annapoli	Ls		Anne	Arun	del			
	5. Social Security Number  216-44-9420  6. Sex 1 ☑ M 2 ☐ F  98			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day Mar 26	Year)	9. Birth Geo:	place (State or Foreign intry) rgia			
	Usual Residence of Decedent						1				
	10a. State 10b. County 10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits			
tor	MD Anne Arundel	Annapo	olis					1 ☐ Yes 2 🔀 No			
Lec	10e. Street and Number		10f. Zip Code			l 0g. Citizen of	What Cou	intry?			
rai Di	9207 River Crescent Drive			21401			ISA				
nue	11. Marital Status  12. Was Decedent Ever in U Armed Forces?	l.S.   13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sr n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ice - Amer ack, White	ican Indian, , etc.			
Be Completed by Funeral Director	1  Never Married 2  Married 1	-46	1 ☐ Yes 2 💢 No	Specify:		Speci	'n; wh∶	ite			
tec	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa	tion	una	16b. Kind of 8	Business/I	ndustry			
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ĕ	12 5+	I	professor			US N	ava1	Academy			
3e (	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Suma	me)				
Tof	Paul Milton Berry			Nancy	Jane Hol	ce					
	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street a			r, City or Towr	, State, Zi	ip Code)			
	Ann Morrison/daughter	P.0	O. Box 2 A	rnold, M	D 21012	2					
			osition (Name of matory or other place	»)	Date	20c. Location	- City or T	own, State			
	21. Signature of Funeral Strvice Licensee Ronald S. Wade, Director	2	2. Name and Address	s of Facility							
	Ronald S. Wade, Director	rs	State Anat	omy Boan	d 655 W	. Balti	Lmore	Street			
	23a. Part1. Enter the disease or complications that caused the deat		Baltimore, terthe mode of dying			rest,		Approximate			
	shock, or heart failure. List only one cause on each line.		•		, ,			Interval Between Onset and Death			
	disease or condition resulting in death)		9					2 days			
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ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
кап	that initiated events c. resulting in death) Last Due to (or as a conseq	uonco of):									
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olet	/				24a. Was a		. Were aut	opsy findings available			
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	25. Was case referred to medical			26 Diana -4 D		2 No	1 🗌 Yes	2 No			
ğ	examiner?	ER/Outpatie	nt 3□ DOA Othe	e	th (Check only or		hor /0-				
É	27. Manner of Death 28a. Date of Injury	28b. Time o			ome 5 Resid			ny)			
tlor	1 Natural 5 Pending (Month, Day Year)	Injury	Work	? ′es 2 ∐No		. ,					
lca	3 Suicide 6 Could not be	ome farm et			28f. Location /S	treet and Num	ber or Ru	ral Route Number,			
erti	4 Homicide determined building, etc. (Specific	(y)	radioly, dilled		City or Tow						
ŏ	29a. Certifier 1X Certifying Physician: To the best of my kno	wledge de-	th coordinates the co	o date and -1-	and due to the	(Augo/a) == 1		stated			
Medical Certification: To Be	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my known one in the basis of examinar and manner stated.	ation and/or in	nvestigation, in my op	e, uate and place inion, death occu	red at the time, o	ause(s) and n late and place	anner as , and due	stated.  1, Day, Year)  2 00 8  2 11114			
ž	29b. Signature and title of pertifier		29c. License	number		29d. Date sign	ed (Month	Day, Year)			
	I and 1/20 rem	MO	100	0245	//	01/	15/	2008			
	30. Name and address of person who completed cause of de (Iten	n 23a) (Tuna	Print)			1	-	-			
	Pail B. Berez, MD 7223	5 F	Defon	se Hun	v. Cri	ton	me	021114			
	31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature _	m (1(1)	1	, ,,	.,					
te ar	JAN 2 8 2008	Ages									
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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Januar P° 23, ≥60\$ **Physician** 2:30A M Melba С. Bowersox /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center OWSOR 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 X F Director 212-07-9169 92 8, 19167 Maryland Jan. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notified 1 ☐ Yes 2**XX**No MD Baltimore Lutherville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with in the filed that hand Mental Hygiene.

The filed TS is marked other than "natural", or items 23a or items to rother traumatic event, the Medical Examiner must be nuy or other traumatic event, the Medical Examiner must be not a filed to the traumatic event, the Medical Examiner must be not an examiner must be not a filed to the traumatic event, the Medical Examiner must be not a filed to the traumatic event, the Medical Examiner must be not a filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the filed to the fi 21093 USA 820 Kellogg Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 XNo Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1+ Printing Company Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ann McGraw Snitzer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James P. Bowersox (son) 820 Kellogg Road, Lutherville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Q1/26/2008 4 Donation 5 Other (Specific ambment Timonium, Maryland Dulanev Valley Mem Gṛđn. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatu 1050 York Road, Towson Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final SEPSIS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leaving L immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed page 2 2 Be P 2 Certification:

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, ours after death.
neral Director; A
filled in by the fu within 24 hours a

To the Funeral 1

completely filled

										24a. Was an autopsy performed? 1∐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
5. Was case refer	red to medical						26.	Place of Dea	th (C	heck only one)	
examiner? 1 ☐ Yes 2 💢	No	Hospital	1 Inpatient 2 □	ER/Outpatient	3 🗆	DOA	Other: 4	□ Nursing H	ome	5 ☐ Residence 6	S □Other (Specify)
7, Manner of Deat 1  Natural 2  Accident	h 5		Date of Injury (Month, Day Year)	28b. Time of Injury	М		Injury at Work? 1 □ Yes	2 🗆 No	280	l. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							Location (Street and City or Town, State)	d Number or Rural Route Number,
29a, Certifier											and manner as stated.

29c. License number

D37254

29d. Date signed (Month, Day, Year)

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To the I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE, TOWSON, MARYLAND 21204 7601 BOON POH LIM M.D. 31. Date filed (Month, Day, Year)
JAN 2 8 2008

State Registrar

Medical

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PANHARY 25 2008 HOPE Μ. BROOMER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ILBUBURNIE BARTIMORE WARHINGTON MEDICIAL tf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 M 2 F 78 Director 072 - 42 - 2172June 8,1929 England Usual Residence of Decedent 10c. City, Town or Location 10a State 10h. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Sarasota Sarasota Florida 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Apt. 403 707 Gulfstream Avenue 34236 Eng1and 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Sales Retai1 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be be ital Beatrice M. Green Fredrick T. Stockman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorene Drive, Pasadena, Md. 21122 Mark A. B<u>roomer</u> (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If item any Injury or othe 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 01-26-08 | Baltimore. 22. Name and Address of Factor 204 Mountain McCully-Polyniak Funeral 21. Signature of Funeral Service Licenses Road Pasadena, Md Home P.A. 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner NEUMONUA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2⊠No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person drive 32 Registrar's Signa 31. Date filed (Month, Day, State

Registrar

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Ralph Calvin Beach January 24, 2008 12:45 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 8105 Streamwood Drive Baltimore Pikesville 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Director 83 Nov. 5,1924 213-16-4255 Washington, DC Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8105 Streamwood Drive 21208 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ρ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Eugene Beach Lucy Ann Leathers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 8105 Streamwood Drive, Pikesville, MD 21208 Wanda Beach 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 1-25-08 Hampstead, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Te M entens ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure /Medical Due to (or as a consequence of): Examiner atheroselerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 TNo 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown coronory opting distore 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ riesidence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Hatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and 619914 1/25/08 1241 30. Name and address completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20, Month **Physician** Adel1 Mary Brown January 2008 3:10pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Health and Rehab Prince George's Largo 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 08/27/1918 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 297-28-4776 1 M 2 TxF 89 Yrs. AL Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend nent of Heatth and Mantal Hygiena. unt: if item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in and Mantal Hygiena. 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, tre Medical Exerciter must be notified at MD Prince George's Fort Washington 1 TYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13103 Rhame Drive 20744 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 þ 1 ☐ Yes 2 TNo Specify: Specify: **Black** 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Laborer General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard Brown Fannie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Lomax / Daughter 13103 Rhame Drive, Fort Washington, MD 20744 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State West Park Cemetery 1/25/2008 Cleveland, OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine sician end buriel-transit or Attending Physician: The law requiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of) attending pl ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown signed I 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ဥ 2 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury Certification: 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after death. ii Director: Aft ed in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) ş 29b. Signatur d title of certifie 29d. Date signed (Month, Day, Yeer) 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 9500 Richmy ANN MOOL no LOMBA 31. Date filed (Month, Day, 1) Year) 2008 32. Registrar's Şignature State

**DHMH 16 Rev 6/95** 

Registrar

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			3600 W. Fran 5. Social Security Number	klin 6. Se			s. last birthday)			more	24 Hrs	C. Data of Birth		0.5:1		
	Funeral Director		216-28-9361 Usual Residence of Deceder	1	_M 2∑F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Nov 19,	^{Year)} 1933	9. Birth Cou	place (State intry)	unk
	/land		10a. State 10b. Co			10c. 0	City, Town or Lo	ocation							10d. Inside C	City Limits
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21215-0036	within 72 hours after death with the Maryland ene. then "natural, or iteme 23e or 28e-f ehow ha Madical Examinar must be invittled at	ed	15. Dece	edent's Ed	ucation	165.	16a. Dece	dent's Usua	I Occupa	ation		unk		f Business/In		unk
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Baltimore,	Depart Import eny in		21. Signature of Funeral	Method of Disposition  Burial 2 Cremation 3 Removal from State  Donation 5 Other (Specify) in state  State  State  Date  20c. Location - City or Town, State  2												
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8760,	ate be executed hysicien and the buriat-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Con	gest Jas a conse ert	tire	Has	er#	F	ail	lure				
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P.O. Box	Physician: The law requires that the death certifica this certificate has been signed by the attending phr ral director, pege 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown			th 2∏Fet nt at time of	tal death 3	Ectopic pre Other (spe						Date of delive Month	_	Year
	as tha	by P	Part II. Other significant con-	ditions co	ntributing to dea	th but not re	sulting in the ur	derlying ca	use give	n in Part I.		23e. Did toba	acco use co	ontribute to th	ne cause of o	leath?
ord	w require been si should t	P	typoth	pso	olisn	<u></u>						1 X Yes	s 2□No	3 🗆 Prob	ably 4 🗀	Jnknown
Records,	The faw rie has be	Completed	glaucon	na								24a. Was an autopsy perform	24t	o. Were auto prior to co death?		available ause of
ita	ian: rtifica for, p	0	25. Was case referred to med	lical			-			26 Place	of Death	perform 1 Yes 2 Check only one		1 ☐ Yes	2210	
f V	nysici nis ce direc	To B	examiner? 1 Yes 2 □ No	F	fospital: 1 🗆 Inj	patient 2	] ER/Outpatien	3 DO	Othe				7	ther (Specifi	iv)	
o uo	nding Pt. th. : After the function		27. Manner of Death  1 Natural 5 Per 2 Accident	nding estigation	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury		c. Injury Work			Bd. Describe how			77	
Division of Vital	i or Atter after des Director	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of building	f Injury - At h g, etc. <i>(Speci</i>	nome, farm, stre	eet, factory,			20	Bf. Location (Stre City or Town,	et and Nur State)	nber or Rura	l Route Num	ber,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Certifier   Medi	lying Physical Exami	sician: To the b ner: On the bas and manne	12 OI BYGHILL	owledge, death ation and/or inv	occurred a estigation,	t the time	e, date and inion, death	place, ar	nd due to the cau d at the time, dat	use(s) and r	manner as si	tated. the cause(s	)
	omple	Me	29b. Signature and title of cer		and manne	. Juliou.			License					ned (Month,		
	->-0		$\rightarrow \wedge \wedge 1$	~ ~ .	10 1	11					50					2
		-	30. Name and address of pers	on who co	empleted cause	of death (Ite	m 23a) (Typa 5	Print)	12	0	20		1 0	0,0		
	Sta		31. Date filed (Month, Day, Ye	A	KHA	pistrar's Sign	A, 29	9,5	. 10	cq 5	Stoe	et, be	elli.	MOR	MDZ	21201
*	Registr		JAN 2 8		100	see A	L Soot	R)								

DHMH 17 Rev 1/2001

			For 1_ State	State of	Marylan		artment of H			lental Hy	/gien	е			
			Registrar			Cei	rtificate of	Death			Reg. N	o. 2 ()	108	018	6
	Physic	ian	Decedent's Name (First, Middle	. ,						2. Date of D Month	Da	ay	Year	3. Time of De	ath
	/Medi		Montrose	S1a		Ca1	trider			Janua		5, 2		8:35 a	M
1	Exami	ner	4a. Facility Name (If not institution	. 0	er)		4b. City, Town, o	r Location of	of Death		4	c. County	of Death		
مقطع			211 Clubside D		A (1	t4 t !-t -t \	Taneyto If Under 1 Year		24 Llvo	0 D-1 ( D	int in	Carr		/0:	
Н	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs.	iasτ birtnday) Yrs.	Months Days	Hours	Min.	8. Date of B	ay, Year	r)	Coun	ace (State or Fo	reign
, had	Director		218-22-9498 Usual Residence of Decedent		79					Nov 24	, 19	28	Mar	yland	
	and		10a. State 10b. County	-	10c. City	y, Town or Lo	cation						10	Od. Inside City L	imits
	Mary f sh	힏	MD Carr	o11	7	Caneyto	own							1 ☐ Yes 2	∏No
	the 28a-	Director	10e. Street and Number				10f. Zip Code				10g. C	itizen of V	Vhat Coun	try?	_
	with Ba or t be	٥	211 Clubside D	rive			21787					S.A.			
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13.	Was Decedent of H	lispanic Ori	igin? (Spe	ecify Yes or N			e - America	an Indian,	
10	fler of riter in the riter	Ξ	1 ☐ Never Married 2 ☑ Mar	Armed Force ried 1 X Yes 2	□No					Rican, etc.)		Blac	k, White,	etc.	
21215-0036	urs a ai", o Exan	þ	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Date	es:		1 □ Yes 2 🖾 No	Specify:				Specify	. Wh	ite	
9	72 ho	Completed	15. Deceder	nt's Education		16a. Dece	dent's Usual Occup	ation	راد من کم د	·	16b. l	Kind of Bu	siness/Ind	ustry	
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21	d wit	Ş		4		Civi	ll Engine	er			MD	State	e Hig	hway De	pt.
þ	al Hy loth	Be (	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle	e, Maide	n Surnam	ne)		
<u> a</u>	uld b Ment rrked rric e	2	Carr	011	Ca1	ltrideı	•		Marg	aret	Sch	aefe	r		
Maryland	12 should be filed w h and Mental Hygie 7 is marked other ti rraumatic event, th	l l	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rura	al Route Num	ber, City	or Town,	State, Zip	Code)	
	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic	ļ.,	Nelly Caltride	er Wi	fe	211	Clubside	Driv	e, T	aneyto	vn .	MD 2.1	1787		
Sre	es 1 of He riten		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	2 Damaual from Ct	1 0	Place of Dispo	sition (Name of matory or other plac	i		Date	20c. l	_ocation -	City or To	wn, State	
Ĕ	r H		4 □ Donation 5 □ Other (5			rroll	Cremation	n J	an 2	6,2008	Ha	mpste	ead.	MD	
Baltimore,	in the state of		21. Signature of Funeral Service	Licensee	**	22	2. Name and Addre			11824					
m	Dep Imp		family	Ling	,	EL	INE FUNE	RAL H	OME	Reist	erst	own,	MD 2	1136	
			23. Part1. Enter the disease, o shock, or heart failure. List	r complications that cau	sed the death	h. Do not ent	er the mode of dyir	ng, such as	cardiac	or respiratory	arrest,			Approximate Interval Between	n
	Physician		mmediate Cause (Final disease or condition	6	1d CH	120	laskis	nne	d	Seare				Onset and Dea	ťh ⁄
$\mathcal{F}'$	/Medical	) inte	resulting in death)	a. Due to (or	as a consequ	u ce of):	()	OI 13		8 Stac				(6)	7
	Examiner			h h											
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	sience of):									
	cate be executed physician and the burial-transit	Examine	that initiated events	c											
o,	an ar	Ě	resulting in death) Last	Due to (or	as a consequ	uence of):					•				
8760,	te be ysicia ne bu	dical		d											
9	The law requires that the death certificate be executed the has been signed by the aftending physician and age 2 should be detached for use as the burial-transit	led		1							1		l		
Box	leath certific aftending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregna h 2 □ Feta		Ectopic pregnancy	,					e of delive		
	deat ne aft ed for	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)					Мо	nth	Day Yea	r:
P.0	at the de by the	hys	9 🗆 Unknown	9EIOTIKITOW	11						ĺ				_
	res tha igned	by F	Part II. Other significant conditi	ons contributing to deat	th but not resu	ulting in the u	nderlying cause giv	en in Part I		23e. Did	tobacco	use conti	ribute to th	e cause of deat	n?
ord	w require been sign	ed								1	Yes :	2□ No	3 ☐ Prob	ably 4 Unk	nown
၁၁	e law re has be	plet								24a. Wa		24b. \	Were auto	osy findings ava npletion of caus	ilable
Ä	The late he	Completed								per 1∐ Yes	opsy formed?	.   .	death?	2 <b>16</b> 0	5 01
Vital Records,	sician: Th certificate rector, pag	(a)	25. Was case referred to medica	d				26. Place	of Death	(Check only					
Z >	ysic is ce direc	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2 🗌	ER/Outpatier	t 3□ DOA Oth	er: 4 🗆 Nı	rsing Ho	me 5 Res	sidence	6 □Oth	er <i>(Specit</i> )	·)	
0	ding Ph h. After th funeral	n: T	27. Manner of Death 1 ☑ Natural 5 ☑ Pendir	28a. Date of	Injury Day Year)	28b. Time o Injury	28c. Injur Wor	y at		28d. Describe	how inj	ury occurr	ed		
<u>.</u>	ath. or: Af	atio	2 ☐ Accident investi	gation	, , , , ,	,,		Yes 2□	No						
Division or	r Attencer death	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	.: Zoe. Place of	injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office			28f. Location City or To	(Street a	and Numb	er or Rura	l Route Number	;
	tal or A s after al Dire ed in by	Certification:										/			
	hours hours uneral		29a. Certifier 1 Certifyii	ng Physician: To the be Examiner: On the basi	est of my kno	wledge, deat	n occurred at the til	me, date ar	nd place,	and due to the	e cause(	s) and ma	anner as st	ated.	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the funer	ledical	one)	and manne	r stated.										
	To the within To the comple	Ž	29b. Signature and title of certifie	Mn			29c. Licens				29d. D	ate signed	d (Month, i	Day, Year) 200	0
			P Crecks	, 5			D	5203			J	an	25	200	0
	1491		30. Name and address of person		of death (Item	23a) (Type,	Λ '		Wes	tmus		N	10 2	1100	
	101			100 291	> ta	vos	Acome			mung	4	( '	10/ 6	11) 1	
1	Sta		31. Date filed (Month, Day, Year)	8 2008 32. Reg	istrar's Signa	ature	254								
	Regist	ali	JANA	O LOUD	Albert Comment	0									

**Physician** /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the for

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, within 24 hours a To the Funeral C

To the Hospital or Attending Physician;

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Certification: To 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 23,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EAS EASTERN AVENUE, BALTIMORE, MD YEHIA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Charles Maurice DeWitt 2. Date of Death .[□]2008 Jan 22, 4:35pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Eadonton Retirement Community Frederick 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (S July 26,1918 Ill 1111115) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Sacial Security Nuraber 327.05.5903 Days Hours Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Md Frederick 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 USA 5901 Genesis Lane. 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Director of Feople Services 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde DeWitt Mary E. Jones 19a Informant's Name/Relationship (Type Print) Catherine D. Graham- Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8128 ClaiborneDrive. Frederick, Md 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a. Method of Disposition 1/24/2008 20c. Location - City or Town, State Catonsville, Md 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke 21. Signature of Funeral Service Licensee Funeral Homes Inc. 22. Name and Aduless of Adules, St. Columbia, Md 21045 M01050 23a. Part1. Enter the isease, or complications that caus shock, or heart failure. List only one cause on each isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4125 Ce quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes ■ No 24a. Was an was autopsy performed? 1∐ Yes 26. Place of Death (Check only one) ASSISTED LIBITURY Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 $\square$ No 2 Accident 3 Suicide

The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760, 3 this certificate has been si al director, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical þ Completed Be Certification: To

Medical

Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Be Completed

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

Lep-rtment of Health a liportant; If item 27 is any injury or other train once.

**Physician** 

/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23

3altimore, Maryland 21215-0036

25. Was case referred to medical examiner?

4 Homicide

29a. Certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

2008

29c. License numbe

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 31. Date filed (Month, Day, Registrar's Signature Year)

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2008 January 23, 11 P. Physician June R. Driggers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Nursing Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) Year | Min. | June 2, 1920 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** West Virginia 1 ☐ M 2 🙀 F 235-20-1849 87 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "national any injury or other than" 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Baltimore Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 3420 Orlando Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Ashcroft Arliss Powell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3420 Orlando Drive Baltimore Maryland 21234 Donald Driggers / Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore Maryland 1/26/08 Parkwood Cemetery 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leoanrd J. Ruck, Inc 21. Signature of Funeral Service Licensee X Welon 5305 Harford Road Baltimore Maryland 21214 Misture 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final pucatre **Physician** disease or condition resulting in death) Due to (or as consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and the burial-traf Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to Division or Vital Records, 2 3 Probably 4 □Unknown 2 No 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 2 ER/Outpatient 3 DOA 1 Inpatient 1 Tyes P After this 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of funeral 27. Manner of Death Certification: or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide filled in by 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

30. Name

31. Date filed (Month, Day, Year

and address of person who completed cause of death (Item, 23a) (Type, Print)

J. CHANVES W) 32. Appistrar's Signature

6101

Towson, Maryland 21204 Onset and Death

Maryland

12:33A

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

Virginia

White

Burke

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

23b. Was decedent pregnant

1 ☐ Yes 2 ☐ No 9 ☐ Unknown

in the past 12 months?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 28

IF FEMALE:

23c. If yes, outcome pf pregnancy

9☐Unknown

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Reg. No.

13,1929

MATHUAR Pay 22, YEROB

10g. Citizen of What Country?

U.S.A.

Specify

June

Towson

16b. Kind of Business/Industry

Health Care

Timonium, Maryland 21093

20c. Location - City or Town, State

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

23 08

1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No

14. Race - American Indian,

Black, White, etc.

4c. County of Death timore

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

Due to (or as a consequence of):

24a. Was an autopsy performed' 2 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29c. License number

D26002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

7601 OSLER DRIVE, TOWSON, MARYLAND 21204 **EPPLER** JR. M. D.

State Registrar

ling physician and e as the burial-transit

been signed by the attending physician should be detached for use as the burial

has

this

Director: After

within 24 hours a To the Funeral C

filled in by the funeral director,

or Attending Physician:

Physician/Medical

ģ

Completed

Be

2

Certification:

Medical

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	•	For State Registrar	State of Iviaryia		rtificate of L			ene g. No. 2	01869
Physicia	an	1. Decedent's Name (First, Middle, Last)  Catherine	Lorraine D	iacont			2. Date of Death Month January	Day 2 Year 2008	3. Time of Death 6:35 p M
/Medic Examin		4a. Facility Name (If not institution, give si		Taconc	4b. City, Town, or	r Location of Death		4c. County of Deat	
LAdiliti	<b>5</b> ا	Gilchrist			Towson	n		Baltimore	e
Funeral Director		5. Social Security Number 6. Sex 219-18-5017 1□	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 4,		nplace (State or Foreign untry) ryland
land t		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Mary Ff sho	tor	Md. Baltimor	e P	arkvill	e				1 □Yes 2 ☑ No
h the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
23a c ust be	ral	3315 Texas Ave.			21234			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	<ol> <li>Was Decedent Ever in Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:</li> </ol>		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖸 No	lispanic Origin? (Span, Mexican, Puerti Specify:	oecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
72 hou natura ilcal E	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occup	ation during most of wor	kina 1	6b. Kind of Business/	Industry
ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	Payro	DO NOT use retired	i)	nn g	Bell Atla	nntic
iled w Hygiel ther ti		17. Father's Name (First, Middle, Last)		Payro	110	18. Mother's Nam	ne (First, Middle, M		allele
d be f ental h ced of	o Be	, , , , ,	pple				Mansfield	,	
shoul nd Me mark	ဍ	19a. Informant's Name/Relationship (Typ	<u>' '                                  </u>	19b. Mailii	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	?ip Code)
and 2 alth a 1 27 is		Mr. Jeff Diacont/ S	on	9223	Bretton	Reef Rd.	Perry Ha	all, Md. 2	1234
of He of He if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	osition (Name of matory or other place			0c. Location - City or	
: Pag tment tant: I ijury o		4 Donation 5 Dother (Specify)	ՄԱ		alley Mer		8-08	Timonium,	Md.
permit Depar Impor any Ir		21. Signature of Furieral Fervice License	1	Į.	2. Name and Addre Ruck 1050	Towson F York Rd	uneral Ho Towson,	ome, Inc. Md. 21204	
		23a. Part1. Enter the disease or complic shock, or heart failure. List only on	ations that caused the de- e cause on each line.	ath. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)			d asp	irntu	n price	morea	W-8823
/Medical Examiner			Due to (or as a conse	equence of):	U		60		
	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quenes of):					
ransitr del	Examiner	that initiated events							
oe exe	Ĕ	resulting in death) Last	Due to (or as a conse	equence of):					
rtificate be executed ng physician and as the burial-transit	edical	d							
The law requires that the death certifute has been signed by the attending bage 2 should be detached for use as	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)	4		23d. Date of del Month	ivery Day <b>Ye</b> ar
that the set by detach	Phy	Part II. Other significant conditions com	tributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
luires signo	d by	Lymphoma					1 □ Ye	s 2 <mark>⊡</mark> No 3□Pr	obably 4 Unknown
aw req s beer 2 shou	lete	0					24a. Was an	24b. Were au	utopsy findings available completion of cause of
The Is	Completed						autopsy perform 1 Yes 2	ned?   death?	2 No
clan: ertifica	Bec	25. Was case referred to medical examiner?	9.1		low		th (Check only one	9)	11
Physic this c	မ	I Tes ZE No	ospital: 1 ☐ Inpatient 2	ER/Outpatie		4 Li Nursing F	lome 5 Resider		city) HOP (100
ding I	ion	27. Manner of Death  1	(Month, Day Year)	Injury	Wor	yai k? Yes 2 ∐ No	Zod. Describe no	w injury occurred	V
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ro , State)	ural Route Number,
e Hospit 24 hours e Funers letely fille	edical (		ician: To the best of my k ler: On the basis of exami and manner stated.						
To th within To th	Me	29b. Signature and title of certifier	10		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
		If thething 1	ily in		1)25	205	J,	Mumy 2	5,2008
Q		30. Name and address of person who con	mpleted cause of death (It	em 23a) (Type,	Print) C+ 6	20 ltn 1	W 2/2	mum, 2	
0	to	31. Date filed (Month, Day, Year)	32. Registrar's Site	mature A	£ 3	prio.	21		
Sta	te .	IAN 2.8 2008	Marian So	1000	Se Acres				

State Registrar (DNI

JAN 2

8

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:45 AM 23 200 8 /Medical 00 4a. Facilify Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cromwell Baltonine Parkulle Cienesis 8. Date of Birth NOV 26 5. Social Security Number 6 Sex if Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min Yean 948 1**X** M 2 □ F Mary and 59 216-52-5732 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov idical Examiner must be notified at Arnold 1 ☐ Yes 2 X No Director Anne Arundel Md. 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? 21012 USA 358 Oak Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced al Hygiene. other than "natura vent, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bartender Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Boucher Grey Thomas Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Julie Vocci/ Sister 9705 Nable Ridge Terr. Gaithersburg, Md. 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State 1-25-08 Dulaney Valley Mem. Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²² Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Ent. the disease, a complic for is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 11 KEMIA 1 week /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and A g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy 2 Deetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an st huma page 2 autopsy performed? certificate 1□ Yes 2 110 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 ☐Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31295 mD 23/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Chizes 21204 Kloesz 50 Sut 70ws-32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 28

Registrar

an	1 - State RegistrarAmend 19b, p  1. Decedent's Name (First, Middle, Althea		061	illicate o	Death	4	2. Date of De Month	Day	Year	3. Time of Death
cal ier	4a. Facility Name (If not institution, Doctor's Commun			4b. City, Town	ham			4c. Cc	ounty of Dea	eorge's
	5. Social Security Number 142–30–1817  Usual Residence of Decedent	5. Sex 7. Age (Ir 1  M 2  F 98	yrs. last birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of Bi (Month, Di 9/6/19	ay, Year)	9. Bir	thplace (State or Foreigr ountry) MS
ctor	10a. State 10b. County	George's	c. City, Town or Lo	tchellv	ille					10d. Inside City Limits 1 Yes 2 □ No
Director	10e. Street and Number 2711 Enterpri	go Poad		10f. Zip Code 2072					n of What Co	ountry?
y Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever Armed Forces? d 1 Yes 2 No If Yes, Give		Was Decedent o	f Hispanic Ori uban, Mexica	gin? (Spe n, Puerto	ecify Yes or Ne Rican, etc.)	0- 14.		_
Completed by	Widowed 4 □ Divorced  15. Decedent's  (Specify only highest  Elementary/Secondary (0-12)	grade completed)	16a Dace	dent's Usual Occ kind of work dor DO NOT use reti	runation	t of worki	ng		of Business	
Som	12	College (1-4or 5+)	Nur	ses' Ai					1th Ca	are
To Be	17. Father's Name (First, Middle, La Eugene Myers	,			Et	he1	(First, Middle	<b>11</b>	,	
	19a. Informant's Name/Relationshi	p (Type. Print) reen / Son	41500	ng Address <i>(Stre</i> - Chenin						Zip Code) 92591 92591-41509
	20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Specific Specific Spe	Removal from State	41598 20b. Place of Dispo cemetery, creating Fillside	osition (Name of matory or other p	place)	C	oate 5/2008	20c. Loca	tion - City or	Town, State
	21. Signature of Funeral Service Li	50,7		2 Name and Add	tress of Facili	tv	rens Fi		Home	Tnc.
	23a. Part1. Enter the disease, or c	U. Monsh	211	1501	East :	Fort	Avenue	e,_Ba1	timore	MD 21230
dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	NA ( MEN)		NA	S_	2			Onset and Death
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 23 No 9 □ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify)				230	d. Date of de Month	elivery Day Year
d by Ph	Part II. Other significant condition	s contributing to death but n	ot resulting in the u	nderlying cause	given in Part I	*		tobacco use		to the cause of death?
omplete				-			24a. Was auto perf 1 Yes	s an opsy ormed?	death?	uutopsy findings available completion of cause of
Be C	25. Was case referred to medical examiner?					of Death	(Check only			3 2 10
ဥ	1 Yes 2 No	Hospital: 1 4 Inpatient 28a. Date of Injury	2 ER/Outpatier	IL OLI DON			me 5 Res			ecify)
Medical Certification:	1 Latural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	(Month, Day Ye	ear) Injury	M 1	njuryat Vork? □Yes 2□ ce	No	28f. Location	(Street and I		iural Route Number,
al Certi		Physician: To the best of m	ny knowledge, deat	th occurred at the	time, date ar		and due to the			
25	(Check only 2 Medical E	xaminer: On the basis of ex and manner stated				ath occurr	red at the time	, date and p	lace, and du	e to the cause(s)
edic	29b. Signature and title of certifier	_	~	29c. Lice	ense number			29d. Date s	signed (Mon	th, Day, Year)

Registrar

08-00567 Anthony T Hicks

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State  Certificate of Death Registrar	Reg. I	No. 000	0 0107
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle, Last) 2.	Date of Death Month Da	y Year	3 Time of Death 1231 hrs
iedicai Exami	Hei	4a. Facility Name (if ner institution, give street and number)  4b. City, Town, or Location of Death	January 20,	4c. County of Death	
		Mercy Medical Center Baltimore			
Funeral Director	3	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.    1	8. Date of Birth(N 05 /04 / 1	Foreig	hplace (State or n untry)
япу		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show	٥	MD Baltimore			1 X Yes 2 No
Maryl	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
th the 23a o	a D	2615 Lauretta Ave. 21223  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	rifu Von or No	U. S. A	can Indian, Black,
Ale Z reath with the Maryland or items 23a or 28a-f she must be notified at once	Funeral	Never Married 2 Married 2 Married 1 Yes 2 No	ican, etc.)	White, etc.	Carrindan, Didox,
1 4 4 6 after death al", or item	by Fi	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: 3	ack
hours a	eted t	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired during most of working life. DO NOT use retired		6b. Kind of Business/	ndustry
36 hin 72 e. than tedical	ıple	Elementary/Secondary (0-12) College (1-4 or 5+)	. 30	Culino	Cu
215-0036 be filed within 7 ntal Hygiene. rked other than	Comple	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	First, Middle, Mai		
ID 21215-00; should be filed with and Mental Hygiene 7.7 is marked other timatic event, the Mex	Be	Jordan Elijah Hicks  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Ru	Belle	Pritche	Zin Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygievier and referent and Heath and Mental Hygievier than "natural", or items 23a or 28a-f she in this tranmatic event, the Medical Examiner must be notified at once	То	Clory B. Hicks/Mother 2615 Lauretta Ave.	Baltin		21223
Baltimore, MC permit. Pages I and 2.8 Department of Health an Important: If item 27 injury or other tramm		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 2	0c. Location - City or	Town, State
		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Woodlawn Cemetery 01/20	6/2008	awynn O	ak mi
Baltimore, permit. Pages 1 at Department of He Important: If ite		21. Signature of Funeral Service Livensee 22. Name and Address of Fability	. Derrich	WJONES	F/H, P.A.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r		timore, No, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive cardiovascular disease			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):		-	
	er	Sequentially list conditions, if any, leading to immediate  b. Cirrhosis of the liver  Due to (or as a consequence of):			
	ıminer	cause. Enter Underlying Cause (Disease or injury that initiated			
uted d ansit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.			
760, icate be executed thysician and the burial - transit	Medical	MENDED AMENDED PII,27, 28a-f, perME,g877, 3/3/08	3 TT		
760, ficate be g physic the burn		23b. Was decedent pregnant in the		23d. Date of deliver	<i>'</i>
Box 687 e death certific the attending p	sician/	past 12 months?  4 Pregnant at time of 5 Other (Specify)	су	Month	Day Year
Bo he deat the at ned for	Phys	1 Yes 2 No 9 Unknown 9 Unknown	1 22 21 11		W
ires that the signed by I	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypothermia		cco use contribute to	bably 4 Unknown
ords, w requires s been sig	Completed	ny podieriida	24a. Was an		utopsy findings available
Records,  The law require ficate has been si	mple		autopsy perform	ed? death?	completion of cause of es 2 No
Vital Recorysician: The law his certificate has the director, page 2 st		25. Was case referred to medical 26.Place of Death (Check or		No 1 🗸 Y	es 2 No
Vita hysicin this ce	To Be	1 V Yes 2 No		esidence 6 Othe	er:
Division of Vital talor or Attending Physician: Its after death.  al Director: After this certicled in by the funeral direction.		(Month Day Year)	28d. Describe ho	w injury occurred	
isior Attencer death rector: by the	icati	Find 1/20/2008 Find 10-//1 am	subject e	xposed to co	old environment
Divi	Certification:	Suicide 6 Could not be determined (Specify) roadway	500° Blk. o	f E. Lexingt	on St. BAltimor
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	due to the cause(	s) and manner as sta	ted.
To the Hos within 24 h To the Fire completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
9	2	29b. Signature and title of certifier  29c. License number  O.C.M.E. OCME		29d. Date signed <i>(Mi</i> January 21, 200	
		30. Name and address of person who completed/cluse of death (Item 23a)			
or perd		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regis	HE I	JAN 2 0 2000			

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Bernice Hoffman 25 2008 N. 0456 AM /Medical January 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Rosedale FRANKLIN SQUARE HOSPITAL CENTER Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 94 Director 212-01-4308 30,1913 Apr. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Directo Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 7 North Kenwood Avenue 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 other Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Jasinski Marie Radomski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Hoffman/Son 604 South Rappolla Street, Baltimore, MD 21224 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cemetery
January 29 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Baltimore, MD 2008 22. Name and Address of FacilityRendon-Bailey Funeral Home, P.A. 21. Signature of Funeral Pervice Lice 360 /м00969 2818 E. Baltimore Street, Baltimore, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myocardial in Farction acute /Medical Due to (or as a consequence of Examiner ardiovascular Disease Se ruentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): Examine and Aldeath certificate be executed Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Dementia 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s 1□ Yes 2⊡No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 1 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier To the Hos within 24 ho To the Fun completely i 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

6

9000 FRANKLIN Square Dr Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

or mada chardon-Borrero

31. Date filed (Month, Day, Year) JAN 2 8 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Daniel Hlaston Month 4:00 P January 24. 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 190-10-9557 1 € M 2 □ F Director May 23,1917 90 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a State 10c, City, Town or Location 10b. County 10d. Inside City Limits items 23a or 28a-f show iner must be notified at Baltimore Dundalk 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 4066 St. Augustine Lane 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Dever Married 2D Married 3 Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🖾 No Specify. þ Specify: 3 ☑ Widowed 4 ☐ Divorced White WWII Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Supervisor 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked Mary Dunay Hlaston ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17314 item 27 I 143 Greenwich Road Delta, Pa (Daughter) Sandra Kagle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1

■ Burial 2 □ Cremation 3 □ Removal from State Bel Air, Maryland Bel Air Mem. Gdns. 1/29/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dûda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Ave. 23a. Part1. Filter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) atteroscleration Physician wan /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 1□ Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Alatural 5 Pending Director: A investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1001 31. Date file State Registrar

			For State	State of Ma	aryland	/ Depa	artment of rtificate of	Health	and M	lental F	Hygie	ne 2 ()	08	01876
	# 3×		Registrar  1. Decedent's Name (First, Middle, Land)	ust)		Cei	unicate of	Deali	,	2. Date of	Reg.	. No.		3. Time of Death
	Physic		Tamara	7	Ivar	nko				Month		Day 21, 20	Year	
	/Medi Examir		4a. Facility Name (If not institution, gi	e street and number)	2,441	110	4b. City, Town,	or Location	of Death	Janua	LLY	4c. County		4:20 p ™
	an later sir un		202 Cork Lane	Apt. 201				erst				Bal	ltimo	re
234	Funeral Director		217-41-7554	Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. Ia 89	st birthday) Yrs.	If Under 1 Year Months Days			8. Date of (Month,	Day, Ye		Coul	place (State or Foreign htry) aine
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation				-			Od. Inside City Limits
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	r 28a	irec	10e. Street and Number				10f. Zip Code				10g.	. Citizen of W	Vhat Cour	ntry?
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	after dea or Items miner mu	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		. 13. \	Was Decedent of f Yes, specify Cul	Hispanic O ban, Mexica	rigin? (Spe	cify Yes or Rican, etc.)	No-	14. Race		ean Indian,
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates;	No		l∐Yes 2⊠ No					Specify:		
9	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	led I	15. Decedent's E	ducation	- 1	16a. Deced	lent's Usual Occu	pation			161	b. Kind of Bu		nite dustrv
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Maryland	d be fi	Be	17. Father's Name (First, Middle, Las  Evtikiv	Lukvaneo				18. Moth		•	dle, Mai	den Surnam	,	
ary	should nd Me mark imarid	ျှ	19a. Informant's Name/Relationship			19b. Mailin	g Address (Stree	t and Numb		Pasha al Route Nu	mber. C	ity or Town		nown Code)
Š	and 2 alth a 27 is		Nadiya Guslitser	Daughter			ork Lane					town,		21136
Baltimore,	es 1 a of He fitem		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Damaval from State			sition (Name of natory or other pla			ate		c. Location -		
ij	ment tant: I		4 Donation 5 Other (Speci				brew Cem		1/24	1/08	R	eister	stow	n, MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examiner.		21. Signature of Funeral Service Lice	Mixim	4m	- 1	. Name and Addr line Fun					sterst		Road 21136
13			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death.									Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. C	ande	ic	why	th mi	2					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):	wet			1	ţ			
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	death certifics attending pl	/Me	IF FEMALE:	23c. If yes, outcome	nf pregnanc	- CV								
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ord	w requir been s should	ted	151 600	el Cana	~ )	13-	rest	*		1	Yes	2 <b>N</b> Vo	3 ☐ Prob	ably 4 □Unknown
Records,	The law cate has b	Completed	Adven	cus c	nippl	Mp	Then	5-tu	<u>d</u>	24a. W	as an itopsy erformed	24b. W	Vere auto	psy findings available npletion of cause of
Vital			25. Was case referred to medical				arthrit	<u>t.                                    </u>		1□ Ye	s 2 🔀		eath? □Yes	2□No
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Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide determined	28e. Place of inju building, etc	ry - At hom :. (Specify)	e, farm, stre	et, factory, office		2	8f. Location City or	n (Street Town, S	t and Numbe tate)	r or Rura	l Route Number,
	spital nours neral / filled		29a. Certifier 1 Certifying Pr	ysician: To the best o	of my knowl	edge, death	occurred at the t	ime, date a	nd place, a	and due to t	he caus	e(s) and mar	nner as si	ated
	he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examinatio	n and/or inv	estigation, in my	opinion, de	ath occurr	ed at the tin	ne, date	and place, a	nd due to	the cause(s)
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			•	0,	•	ins	D	201	1.8		C	1- 2	23.	-08
	_ \		30. Name and address of person who	361.0	_		KIDT	4 F	RAT		m			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	re de	ed 8	- 0,	JMC	**	10	213	215	
	Registr	ar	31. Date filed (Month, Day, Year)	Baras	A. C.	STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY								

DHMH 17 Rev 1/2001

08-00626 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles V. Kestler, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 22, 2008 Year 1858 hrs Medical Examiner Charles Vernon Kestler, 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Baltimore St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 6. Sex **Funeral** Months Days Hours Min Director Country) MD 217-38-2793 05/20/1941 1 X M 2 66 Usual Residence of Decedent any 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No or 28a-f show s 23a or 28a-f shov e notified at once. MD Howard Elkridge death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6608 Pheasant Drive 21075 United States Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 XX Never Married 2 Yes 2X No Divorced Widowed If Yes. Give Year Yes 2 X No specify. Specify: White "natural". 2 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. event, the Medical marked other than 5+ Health Inspector Prince George's Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles V. Kestler, Sr. Dorothy Riley 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carol Lynn Heber - sister item 27 9873 Century Drive, Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition permit Pages 1 a
Department of He
Important: If it crematory or other place) January 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Mem. Pk 28, 2008 Other Specify. Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00053 Gary L. Kaufman Funeral Home at 7250 Wash. Blvd Elkridge Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart nroximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease *<u>raminer</u>* or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed.

Within 24 hours after death.

To the Funeral Director: After this certificate has been simmed but the time. attending physician and or use as the burial - transi Physician/Medical UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Dav Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 ned by the atter detached for u Yes 2 No 9 Unknown 9 Unknown this certificate has been signed by I director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✔ No 3 Probably 4 Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page 2 No Yes 2 ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 2 FR/Outpatient 3 Nursing Home 5 Residence 6 Inpatient 1 V Yes No ieral Director: After ifilled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 23, 2008 mo 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Josephine Helen King 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rosedole Franklin Square Lospital

5. Social Security Number 6. Sex 7. Daltimore 'enter If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, July 25, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖫 F 90 Maryland 218-05-4176 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r 28a-f show notified at 1 ☐ Yes 2 ☑ No Baltimore Director Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or USA 21221 1 Eastern Blvd. r than "natural", or Items 23a the Medical Examiner must t Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Orlak Sophie Hrekchk Ith and Ment 27 Is marked traumatic e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stabilizer Drive, Baltimore, MD 21220 Marlene Vlachos / permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 大いの Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/28/2008 Parkwood Cemetery Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Leonard J. Ruck, Ir 5305 Harford Road 21. Signature of Funeral Service Licensee Hton X Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 XNo 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 2 No DEC 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28a Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) 5 Pending investigation **★** Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C completely filled i 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifie 66306 01-25-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MD 0/237 Samantha 000 31. Date filed (Month, Day, Year) 32! Agjistrar's Signature State Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0036

lospital or Attending P. hours after death. uneral Director: After t

State Registrar

to aug 31. Date filed (Month, Day, Year)

29b. Signature and title of cortifier

(Check only

one)

JAN 2 8 2008



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 8876 2-5-08 vt State of Maryland Department of Health and Mental Hygiene 1 - State Amend #1, perMD, g876, 2/7/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) Melvinnia Priscilla Kenion 3. Time of Death 2. Date of Death 01/ **Physician** 177 2008 15:51 PM Pricilla Melvinna /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2X F Yrs. 72 231-42-3279 06/12/1935 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No la or 28a-f she t be notified a Grasonville Queen Anne's MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21638 U.S.A. 107 Aslan Court items 23a o Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Dever Married 2D Married 1 ☐ Yes 2 No Specify: Specify: Black ò Baltimore, Maryland 21215-0036 ð 3 Widowed 4 Divorced "natural" Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) event, the Medical (Give kind of work done during most of working life. DO NOT use retired) within College (1-4or 5+) Is marked other than Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than Government Procurement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Martha Willie Patillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Katima A.Wilson - Daughter 107 Aslan Court Grasonville, MD 21638 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of P
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 1/25/08 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm 21. Signature of Funeral Service Licensee 108 W.North Ave.Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLZEINERS DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year in the past 12 months? 5 Other (specify) signed by the a ☐Yes 2☐No 9 Tillnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗇 1 Yes 2 No certificate 1 Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 🗀 Inpatient 1 ☐ Yes Certification: To this al or Attending Phy.
s after death.
Il Director: After this
of in by the funeral di 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide filled i To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D0058290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIVERDALE My 2072 STIL SARVIC AVENUE SOFIE 200 MUTTATION SORESH KUMBR Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

08-00660 Edward F. Kness Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edw	ard F. Knes	SS	1- For State Registrar	tate of Maryland	/ Departmer Certificat			l Menta	al Hygiene	Reg. N	200	8 0188
B#a	Physici dical Exam		1. Decedent's Name (First, Midd				•		2. Date of Month	Death		3. Time of Death 1656 hrs
Med	ilcai Exam	mei	4a. Facility Name (if not institution		ness	4b.	City, Town, or L	ocation of	Month Januar Death	y 23, 2	2008 4c. County of Deat	
<b>₹</b>	)		Greater Baltimore Me	edical Center		7	owson				Baltimore Co	unty
	Funeral Director		5. Social Security Number		ge (In yrs. last birthd	_	f Under 1 Year Months Days		Min.		/M/DD/YYYY) 9. Bi Forei	an
	Director		220-36-0905 Usual Residence of Decedent	1 X M 2 F	69	Yrs.			Sept	. 14	4, 1938 ^{co}	ountry)Maryland
	any		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Maryland 28a-f show any d at once	or		altimore			Sparks					1 Yes 2 X No
0	e Mary or 28a-	irect	10e. Street and Number			1	Of. Zip Code			10g. (	Citizen of What Cou	·
11.46	with th s 23a ( e notif	Funeral Director	2002 Far Out	t Lane P.O.		3. Was D		21152	? (Specify Yes o	r No-	USA 14. Race - Ame	rican Indian, Black,
حد.	death or item nust b	nue	1 Never Married 2 X N	Married Armed Forces					Puerto Rican, etc.		White, etc.	
	s after ral", o	by F		vorced If Yes, Give Year or Dates:			s 2 X No			1.0		hite
	2 hour natu	Completed by	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>		du		of working life.		nd of work done se retired)	16	b. Kind of Business	Industry
	036 vithin 7 ene. er than Medica	mple		5+	S	yste	ms Engi	neer			Techn	ology
	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle				1	8.Mother's	Name (First, Midd			
	212 ould be I Menta mark ic even	To Be	Edware 19a. Informant's Name/Relations			Mailing Ad	idress (Street	and Numb		C. Number	Boetler City or Town, State	e, Zip Code)
	MD and 2 short and m 27 is aumatic	4	Mrs. Kay Knes	s/Wife	200	2 Fai	r Out L	n. P.	0.Box545	Spa	arks, Md.	21152
Ser.	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nethell Hygiens (Important: If item 73 is narked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Crematio	n 3 Removal from S	20b. Place of I crematory	or other	place)	,	Date		Oc. Location - City o	
	Baltimore, permit. Pages I ar Department of Hee Important: Ir iter mjury or other tr	3	4 Donation 5 Other S 21. Signature of Fuperal Service		Dulaney	Val	ley Mem	. Grd	. 1/28/0	8 T	imonium,	Maryland Home, Inc.
	Balt permit. Departi Import injury	85 14	Muchael	1 Ruest		105	O York	Road	Towson.	son Mar	runeral ryland 21	Home, Inc. 204
	Physician		23a. Part I. Enter the disease failure. List only one cause		d the death. Do not e	enter the r	node of dying, s	such as car	diac or respirator	arrest,	shock, or heart	Approximate Interval Between Onset and
(	/Medical çaminer	(6 N	Immediate Cause (Final disease or condition resulting in death)	a. Complicati		s						Death
			Sequentially list conditions,	b. Cholonait								
		iner	If any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons		tue n	ost ramot	-a whir	nle proced	luro	for	0.0
	₩	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of): QUOC	enal	carcinone	a with	pre proce	iare .	101	
	ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refeath. Acter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Aedical E	X UNPENDED	d				<del>-</del>	··-			<u> </u>
	60, ate be o	Medi	IF FEMALE:	23c. If yes, outco	c, 27, per	ME,g8	77_3/6/08	3 TT			23d. Date of deliver	ry
	30x 6876 death certificate e attending phy for use as the	ian/	23b. Was decedent pregnant in t past 12 months?	he 1 Live birth	2	Fetal	_	Ectopic p	oregnancy			Day Year
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	of Vital Records, P.O.  g Physician: The law requires that the this certificate has been signed by neral director, page 2 should be detact.	ted					<del></del>	_	_	Yes 2 Vas an		obably 4  Unknown  utopsy findings available
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	tal Recition: The certificate		25. Was case referred to medica	al I			26 Place	of Death (C	1 ✓ Y	es 2	No 1 <b>✓</b> Y	es 2 No
	Vita hysicia this cer I direct	To Be	examiner? 1 ✓ Yes 2 No	11 . 3.1	ent 2 🗸 ER/Outp	atient 3		Othor:	Nursing Home 5	Res	sidence 6 Othe	er:
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OK	with Fare	Medical	2 Medical Exa 29b. Signature and title of certific	aminer: On the basis of exa and manner stated	amination and/or inve	estigation	in my opinion,		irred at the time, o		place, and due to to d. Date signed (Mo	
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	A.	ŀ	30. Name and address of persor		death (Item 23a)		1				-	
	1		Donna M. Vincenti, M			111 P	enn Street,	Baltimor	e, MD 21201			
	St Regist	ate trar	31. Date filed (Month, Day, Year)	2008 Registra	ar's Signature	Esti-	ÿ					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh 9876 2-5-08 vt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year 7:09 PM JANUARY 2008 /Medical Robert Lee Lover 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Southern MD Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F Director 72 577-46-2787 Usual Residence of Deceden -22-1935 Georgia Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. la or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Capitol Heights P.G. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 West Mill Ave. 20743 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 DX es 2 15 to 1957–59 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Støkes ပ Moses Lover 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 West Mill Ave, Capitol Heights, Md 20743 item 27 i Eleanor C. Lover/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 Cremation 3 Removal from State Harmony Cemetery 1-28-2008Landover, Mg
22. Name and Address of Facility Ronald Taylor II Funeral Hm 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final ARRYThmia **Physician** CARDIAC FATAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner andiopulmonory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-trans 0 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Acidosis Physician/Medical the attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Ketoacidosa 1 Tyes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy Bartera Yes 120 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY Z3rd ZOOS 00052865 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Hospitol

32. Registrar's Signature

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Chevery

			1 – For State Registrar	State of Maryland		rtment of F				21	ากต	01000
E.			Decedent's Name (First, Middle, Last)			imouto or	Douth	2	Date of Deat		J () ()	3. Time of Death
	Physici Medio		Robert Floyd Luck	ey					MINUAR	(Y 19,	Year ElZII	28 5:00AM
	Examir		4a. Facility Name (If not institution, give str Saint Joseph	eet and number) Medical Ce	nter	4b. City, Town, o		of Death TOWSO	m	4c. Count		ltimore
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birth	nplace (State or Foreign
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	death ms 2	Funeral Director	11. Marital Status	. Was Decedent Ever in U.S	6. 13. V	Vas Decedent of F Yes, specify Cub	Hispanic Orig	gin? (Specif	y Yes or No-			ican Indian,
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/ Fu	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		Yes, specify Cub	san, Mexican Specity:	n, Puerto Rio	can, etc.)		ck, White	
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ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	0.0	ace of Dispos metery, cren	sition (Name of natory or other pla	ce)	Date	9 2	20c. Location	- City or T	own, State
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 It any injury or other tra		21. Sign yure of neral Service, icensee Ronal S. Wa	de, Director		Name and Addre			55 W.	Baltim	ore S	Street
÷			23a. Part 1 Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death		1timore, er the mode of dyin			espiratory arre	est,		Approximate
	Physician		Immediate Cause (Final disease or condition	ASPIRATIO	N PNI	-IIMONTA						Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		new Year' E Theor E 'E als E E						
	Examiner	,	Sequentially list conditions b.									
	p #	ine	Sequentially list conditions, if any least it is a cause. Enter Underlying Cause (Disease or injury	Dire fo (ur ав а полвеци	ence of):						-	
	cate be executed ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	once of):							
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687	ficate phys s the	edical	d									
Box (	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	. If yes, outcome pf pregnar					7	23d Da	ate of deliv	/An/
ň	death a atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□Fetal 4□Pregnant at time of de		Ectopic pregnancy Other (specify)	у				onth	Day Year
0	t the by the ache	hys	9 Unknown	9□Unknown								
	The law requires that the de te has been signed by the a lage 2 should be detached	by P	Part II. Other significant conditions contri		ting in the un	derlying cause giv	ren in Part I.		23e. Did tob	acco use con	tribute to	the cause of death?
g	w require been signature	ed	CONGESTIVE HEART FA	AILURE				[]	1 ☐ Ye	s 2⊠No	3☐ Pro	bably 4 Unknown
ပ္ပ	law ras be	plet							24a. Was an		Were aut	opsy findings available ompletion of cause of
Vital Records,		Completed							perform	red?	death? 1 ☐ Yes	2 No
VII.8	iclan; sertific ector,	Be (	25. Was case referred to medical examiner?	-:		1		of Death (C	heck only one	)		
ō	Physical this call dire	ို	1 163 220 100		R/Outpatient		4 LI NUI		5 🗆 Reside			(fy)
u C	ding 1. After funer	io iii	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2∐1		. Describe ho	w injury occur	red	
DIVISION	death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At hor	ne farm stre		res Z		Location /Str	not and Numi	ar or Rus	al Route Number.
2	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		,,,		201.	City or Town,	State)	ol ol mul	ai riodie i <b>v</b> anibei,
	To the Hospital or Attending Physiclan: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director; the funeral director.	<u>a</u>	29a. Certifier 1 💢 Certifying Physic	ian: To the best of my know	ledge, death	occurred at the tir	me, date and	d place, and	due to the ca	use(s) and m	anner as	stated.
	n 24 h	edical	(Check only 2 Medical Examine one)	r: On the basis of examinati and manner stated.	on and/or inv	estigation, in my o	opinion, deat	th occurred	at the time, da	ate and place,	and due	to the cause(s)
	To the Com	ž	29b. Signature and title of certifier			29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)
			1 CAR	~		D	3725	54		1/10	1/08	3
			30. Name and address of person who comp	oleted cause of death (Item	23a) (Type, F	rint)					-	
						R DRIVE	. TOV	WSON.	MARY	LAND	2120	14
	Sta Registra		31. Date filed (Month, Day, Year)  JAN 2 8 2008	32. Registrar's Signatu	Jeses A							
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Baltimore Mary lano

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JAN 28

31. Date filed (Month, Day, Year)

5901

32. egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:05 P.M 1-21-2008 Theresa Ann McKnight /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Burtonsville HolyCross Rehab. Montgomery

9. Birthplace (State or Foreign
Country) H Under Pear H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1941 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Days Hours 1 □ M 2 🕱 F Yrs. Director Wash.,DC 578-54-4465 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Georges 1 XYes 2 No Director Suitland MDPrince Geroges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 20746 4726 John Street U.S.A. 238 within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify: Specify Black Completed by 3℃ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Supervisor Housekeeper Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be fill thent of Health and Mental H tant; if item 27 is marked ot! Thelma I. Jackson William J. Holeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4726 John St. Suitland, Md 20746 other Brenda D. _McKnight 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition Landover, Md 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II ronald 108 W. North Ave. Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metastatic ovarion Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hthknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2.2NO certificete 1 Yes 2 Xio 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division 1 XNatural 5 Pending investigation s efter de. •• Director: Alte ••• the fu 1 Tes 2 No М 2 Accident 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral D 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054566 1/22/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheonelia Avenue Skit 1-17, Silverspring PID 2090 Sunitera Bhogavilli
1. Date filed (Month, Day, Year) 32.1 9801 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 28 Registrar

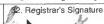
#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MINTON 2008 11CHARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Malical System. BATIMONE Univelsity of Mayers | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 12/14/1962 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 ☐ F 21992093 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at Rosedale Maryland Baltimore 1 ☐ Yes 2K No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medi-ai Ex-miner must be U.S.A. 21237 8303 Berkfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Cook 12 should be filed w h and Mental Hygie 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental important: If item 27 is marked of any Injury or other traumatic every Gladys A. Rasnake James Buford Minton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8303 Berkfield Road, Baltimore, Maryland 21237 19a. Informant's Name/Relationship (Type. Print) James Minton, Sr. (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 01/30/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Firef the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, if heart failure. List only one cause on each line. Immedius Cause (Final disease or condition resulting in death) **Physician** Sugarchio Hemotoma 4 days /Medical Due to (or as a consequence of): Examiner Sub denal hema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed Skull Fract and as the burial-trar Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 2 🗆 No the detached 9□Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 No Physician: 25. Was case referred to medical examiner? 1 X Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation ■ Natural LIUUP 2 Accident 22 08 1 Tes Siruck By Utitizet 28f. Location (Street and Number or Rural Route Number, City or Town, State) Possedale, MD 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

Downing

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennatt Richard

To the I

Baltimore,

P.O. Box 68760,

Division or Vital Records,

29c. License number

S. Greene St.

29d. Date signed (Month, Day, Year)

Please Typ

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tate of Maryland / Department of Health and Mental Hygiene 00	0	8	8	7
Certificate of Death				

			1 = For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certificate of Death	Reg. I	No.	0100,							
			Decedent's Name (First, Middle, Last	1)		2. Date of Death		3. Time of Death							
	Physici /Medio		Doris Martin			Japuary	Day9 2008	6:00AM							
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	71	4c. County ol Death								
			Keswick Multi C	enter	Baltimore										
	Funeral Director		5. Social Security Number 6. Se 148–20–7965	x 7. Age (In yrs. last bi □ M 2∏F 80	irthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yes Sept 29,	ar) 9. Birthpl Coun.	ace (State or Foreign try) unk							
	p ,		Usual Residence of Decedent  10a, State 10b, County	10c City Tou	vn or Location		14	Od. Inside City Limits							
	aryla ehov	2	MD 100. County					1√2 Yes 2 No							
	Ba-f	ecto		Baltimo		1.5	0::1	<u> </u>							
	Mith 1	ä	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	.ry r							
	s 23	rai	700 W. 40th Stre	12. Was Decedent Ever in U.S.	21211	tandu Van as Na	USA 14. Race - America	an Indian							
	ltem Der de	in	11. Marital Status Unk  1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2X No	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	to Rican, etc.)	Black, White,								
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23a or 28s-f ehow ta Medical Examinar must be notified at	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🎇 No Specify:		Specify: whi	te							
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212	r the	Completed	Elementary/Secondary (0-12) unk unk	College (1-4or 5+) ink											
Þ	s 1 and 2 should be filed within 72 hours after death with the Marylan if Heelth and Mental Hyglene. Item 27 is marked other then "neturel", or Items 23s or 28s-f show other treumstic event, the Medical Exercities must be notified at	BeC	17. Father's Name (First, Middle, Last)		unk 18. Mother's Nar	me (First, Middle, Maid	den Sumame)	unk							
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ar	and land		19a. Informant's Name/Relationship (T	ype, Print) 19l	b. Mailing Address (Street and Number or Ru	ural Route Number, Cit	ty or Town, State, Zip	Code)							
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ore.	of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	comote	of Disposition (Name of ary, crematory or other place)	Date 20c.	. Location - City or To-	wn, State							
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Baltimore,	permit. Pages 1 and 2: Department of Heelth as Importent: if item 27 ie eny injury or other treu		21. Sig ature of Funeral Service cons	Tale, Director	State Anatomy Boar		Baltimore :	Street							
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7	/Medical		disease or condition resulting in death)												
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		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):										
	The law requires thet the death certificate be executed sie hes been signed by the attending physicien end page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury	C											
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	ntifica ng ph as th	Aed	IF FEMALE:												
Вох	eath cer attendir tor use		23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	h 3 Ectopic pregnancy		23d. Date of delive								
	death	sicia	in the past 12 months? 1 Yes 2 No	4☐Pregnant et time of death 9☐Unknown	5 Other (specify)		Month	Day Year							
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	ng P fter t		27. Manner of Death 1 ☑Natural 5 ☐ Pending		Time of lnjury at Work?	28d. Describe how in	njury occurred								
Sio	Attending r death.	cati	2 ☐ Accident investigation		M 1 Yes 2 No										
Division	i or Attending Phy atter death. I Director: After this d in by the tuneral d	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, I building, etc. (Specify)	arm, street, factory, office	28l Location (Street City or Town, St	t and Number or Rura. tate)	Route Number,							
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	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	29a. Certifier 1 ☐ Certifying Phy (Check only one)	rsician: To the best of my knowledginer: On the basis of examination and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the cause urred at the time, date :	e(s) and manner as st and place, and due to	ated. the cause(s)							
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			Mabelle Tack	pegu mis	713657	Ja	mary 22,	2008							
			30. Name and address of person who c	ompleted cause of death (Item 23a)	(Type, Print) 40 th Street, Balto	Maria									
			VIJASQUE The	TRESTER, TOO W.	TO The street 15alto	Ila elell									

State Registrar

37 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 2 8 2008

State of Maryland / Department of Health and Mental Hygiene UUS 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2345 AM Mack 600me 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Summit If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 F 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. Yrs. 81 Director 220-20-3543 July 18, 1926 Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28s-f show 10a. State 10b. County 1 Yes 2 No Directo Maryland Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 600 139th Street 21842 USA permit. Pages 1 end 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examinar meatled page. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 □ Divorced WW 2 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Contractor 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Kruger Adolph Gustav Mack ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 Red Oak Court, Cedar Knolls, NJ Stephen Mack (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 1/26/08 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., shock, or heart failure. List only one cause on each line. 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metochic Prosted **Physician** you, 1 /Medical Due to (or as a consequence of): Examiner YOU. marchine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760; Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Day Month Year 4☐Pregnant at time of death isigned by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificete has been si rector, page 2 should Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25 No 2.0 No 1 ☐ Yes Division of Vital director 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2√No this. After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after dei To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 19 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1062757 441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 Baskaran 3455 Defencic

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 8 2008

32. Registrar's Signature

Sandra C. Palmer	State of Maryland / Department 1- For State Registrar Certificate	of Death	.g. No. 2008 01889
Physician/	Decedent's Name (First, Middle,Last)	2. Date of Deat Month January 1	h 3. Time of Death Day Year 1030 hrs
Medical Examiner	Sandra C. Palmer  4a. Facility Name (if not institution, give street and number)	January 1  4b. City, Town, or Location of Death	7, 2008 1000 113
	255South Potomac Street	Hagerstown	Washington
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  168-34-1674 1 M 2X F 65	Months   Dave   Hours   Min	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary Land
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
<b>≜</b> 'a	MD Washington Hager	stown	1 Yes 2 X No
with the Maryland ms 23a or 28a-f sho notified at once be notified at once eral Director	10e. Street and Number 255 S. Potomac Street 3rd f1r	10f. Zip Code 1 21740	0g. Citizen of What Country? USA
r death with , or items 23	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
hours after 'natural", c Examinec.		Yes 2 X No specify:  Ident's Usual Occupation (Give kind of work done unk	Specify: white
nn 72 ran ical	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use retired) unk	unk
1215-0036 de filed within 72 fental Hygiene, tarked other than event, the Medical Decomples	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	Maiden Surname)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	Charles Russell Butts 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Doris Boppe    Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   Doris Boppe   D	nber, City or Town, State, Zip Code)
MD 2 shoulth and M 27 is n aumatic	i i	318 McIntosh Circle Clear	T.
re, restand	20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite	4 Donation 5 X Other Specify: in state		
Ball permit Depar Impor	21. Signature of Fineral S. r. elicensee Ronal S. wage Director	2 Name and Address of Facility State Anatomy Board 655 W Baltimore, MD_ 21201	. Baltimore Street
Physician	23a. Part I. Enter the disease, of complications that caused the death. Do not ent fàilure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory an	est, shock, or heart Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular I Due to (or as a consequence of):	Disease	Death
je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ted Insit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
50, te be executed sysician and burial - transit	UNPENDED AMENDED		
Ox 6876 eath certifica e attending ph for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
P.O. B es that the d gened by the of detached	Part II. Other significant conditions contributing to death but not resulting in t		obacco use contribute to the cause of death?
Records, P.C. The law requires that ficate has been signed. Expect 2 should be derected by	Cachexia	1Ye	s 2 No 3 Probably 4 Unknown  an 24b. Were autopsy findings available
cords, law required has been a 2 should		auto	
Vital Recysician: The his certificate director, page	25. Was case referred to medical	1 ✓ Yes 26.Place of Death (Check only one)	2 No 1 Yes 2 No
f Vital Physician or this cert ral directo	examiner?  1 V yes 2 No  Hospital: 1 Inpatient 2 ER/Outpar	Othor	Residence 6 🗸 Other: Scene
on of value of the true funeral		e of Injury 28c. Injury at Work? 28d. Describe	how injury occurred
Division of Vital Records, spital or Attending Physician: The law require tours after death.  neral Director: After this certificate has been sin filled in by the funeral director, page 2 should be Certification: To Be Completed	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death of the death	occurred at the time, date and place, and due to the caustigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To cor	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	January 19, 2008
	Margarita Korell MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD 21201	
State Registra		W	
DHMH 17 Rev 1/2001	ORIGI	NAL	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32: Registrar's Signeture

2008

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 26, 2008 6:05 Ruckle Edward Homer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center Essex 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/19/1933 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 215-30-3086 74 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f sharer must be notified W. Va. Hampshire 1 ☐ Yes 2 No Augusta Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 71, Box 139 C 26704 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No 1951— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 □ Divorced 1975 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Armed Forces of the Elementary/Secondary (0-12) College (1-4or 5+) United States of Amer. Soldier Department of Health and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, <u>th</u> once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett Ruckle Gladys Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Richardson (Sister) 800 Bengies Road, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XX Gurial 2 ☐ Cremation 3 ☐ Removal from State 02/05/2008 | Arlington Nat'l Cem. 4 ☐ Donation 5 ☐ Other (Specify) Ft. Myer, Virginia 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fight rates vice Licensec 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme ate Cause (Final disea e or condition result in im death) **Physician** Small week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consequence of Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Year Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ₩hknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2**X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No ပို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 1. Natural 5 Pending investigation nours after death.

neral Director: A

y filled in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie,

State Registrar

DHMH 17 Rev 1/2001

Macq

Baldo,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year)

			State of Maryland / Departme	nt of Health and M		ZUUB	01893		
			1- State Registrer Amend #30 perDVR, g875, 1/28/08 TTCertifical 1. Decedent's Name (First, Middle, Last)	le of Dealif	2. Date of Death	J. No.	3. Time of Death		
4	Physici /Media				January	23, Year 200	8 11:40 M		
	Examir		4a. Facility Name (If not institution, give street and number) 4b. Cit	y, Town, or Location of Death		4c. County of Death	1		
			Ruxton Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Und	Denton er 1 Year   If Under 24 Hrs.	0.00	Carolin			
	Funeral Director		5. Social Security Number 2 18 - 09 - 8 4 2 4 1 2 M 2 F 7. Age (In yrs. last birthday) 1 ft Und Months	s Days Hours Min.	8. Date of Birth (Month, Day, 1	(ear) 9. Bint Ook 916 Vir	nplace (State or Foreign untry) ginia		
	ס		Usual Residence of Decedent			7.0 1.22			
	Maryla f shov	lor	10a. State 10b. County 10c. City, Town or Location Federal	sburg			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	or 28a	Director	10e. Street and Number 10f. Z	Zip Code	100	g. Citizen of What Co	untry?		
	23a c	raiD	305 Gardens Ct.	21632		USA			
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Medical Examinar must be notified at	by Funerai	3 Widowed 4 Divorced If Yes, Give Year or Dates:	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto l 2 M No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.		
5-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade completed) (Give kind of w	ual Occupation	ina 16	6b. Kind of Business/I	ndustry		
21215-0036	filed within Hygiene. ther than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) We 1	vork done during most of working use retired) der	l l	Private			
d 2	illed Hygi other	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Ma				
ylar	2 should be filed within and Mental Hygiene. Is marked other than aumatic evant, the Me	To B	Henry Richardson	Cecilia	a Bu:	rton			
Maryland	id 2 should lith and 27 is ma			ss (Street and Number or Rura echen St. #2					
Pauline Richardson/ Wife 301 McMechen St. #206 Baltimore, MD 2121  20a. Method of Disposition    Date   20c. Location - City or Town, State									
1   Burial 2X  Cremation 3   Removal from State   1   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200   200									
Ball	permit. Pag Department Important: I any injury o	more, MD	1						
ı	22		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause in each line. Immediate Cause (Final			100000 PO	Approximate Interval Between Onset and Death		
	Pnysician /Medical		disease or condition resulting in death)  a  Due to (or as a consequence of);	VL03ABIE	1455HE	MERS	4542>		
Ē	Examiner		Sequentially list conditions						
	led sit	Examiner	Sequentially list conditions, if any, facting to immediate cause. Enter Underlying Cause (Disease or injury						
Ć.	be executed sician and burial-transit	Exan	that initiated events c						
8760,	cate be ex hysician the burial								
9	ertifice ling ph e as tl	Med	IFFEMALE:						
О. Вох	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1			23d. Date of deliver Month	very Day Year		
Δ.	s that t ned by e detai	by Ph		cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
rds	w requires been sign should be				1 Yes	2 No 3 Pro	bably 4 🗍 Unknown		
Vital Records,	e law re has be je 2 sho	Completed	JUSCULAR DISEASE, CHR	LONIL	24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of		
<u> </u>	25. Was case referred to medical examiner?  1 Yes 25/No Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA  26. Place of Death Check onlone  Check onlone  4. Nursing Home 5 Residence 6 Other (Specify)								
	ding Phy h. After thi funeral				28d. Describe how				
siol	Attanding in death. actor: After by the funer	catic	2 Accident investigation M 3 Suicide 6 Could not be 180 Place of Injury. At home farm clash forth	1 Yes 2 No					
Division	al or Attand after death Diractor; , d in by the f	Certification:	28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ry, office 2	28f. Location <i>(Stree</i> City or Town, S	et and Number or Rui State)	al Route Number,		
	To the Hospital or, within 24 hours after To the Funaral Director of the Funaral Director the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funaral Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the Funara Director of the	edicai C		d at the time, date and place, a in, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	9c. License number		. Date signed (Month			
,			My Man and address of parson who so plated cause of death (from 23c) (Time Reigh)	D005304	7	-24-	LIVE		
	A		30. Tame and address of person who completed cause of death (Item 23a) (Type, Print)  Paul Matthew Reinbold, MD Ruxton Nursin Home						
	Sta		31. Date filed (Month, Day, Year)  32. Rugistrar's Signature						
	Registrar JAN 2 8 2008								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24 ANNE JANUARY ROTER 2008 5:40P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4730 ATRIUM COURT, #369 OWINGS MILLS BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sirthpio Country NY 1 □ M 2 🕏 F 1271071913 079-22-4545 94 **Director** Usual Residence of Decedent 10c. City, Town or Location 10b. County Show 10d. Inside City Limits r 28a-f show notified at BALTIMORE 1 ☐ Yes 2 ☐ No Director OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 4730 ATRIUM COURT, #369 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify. <u>ک</u> Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME s 1 and 2 should be filed voil Health and Mental Hygic item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other item 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is marked other items 27 is 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL MICHAEL KOLODNY PESHE BAILE UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 DEBRA ROTER / DAUGHTER 2214 W. ROGERS AVENUE, BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CONG. 01/25/2008 BALTIMORE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause that underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dementian 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2**X**(No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only within 2 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 8 2008

2411 NiBelvedere Dre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of	ıvıaı yıaıı		rtificate of		ı Mentai Hy	-	008	0189
1	Physici /Medi		Decedent's Name (First, Middle, I Patsy Anne McN	,	ecki				2. Date of Do Month <b>Januar</b>	Day	Year 2008	3. Time of Death 5:23 A ^M
	Examir		A. E. W. M. W. M. W. M. M. M. M. M. M. M. M. M. M. M. M. M.						unty of Death			
	-63		5351 Green Brid				Dayt				Howar	_
L	Funeral Director		241-36-7237	Sex 7. 1 □ M 2 ₩ F	Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours Mi		nth ay, Year) 1928	9. Birthp Coun North	lace (State or Foreign try) Carolina
	land w t		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation				11	0d. Inside City Limits
Z15-0036	Mary -f sho ied a	tor	Maryland Howard	٩		D	avton					1 ☐ Yes 2 🕍 No
	r 28a	irec	10e. Street and Number			Dayton 10f. Zip Code				10g. Citizen of What Country?		
	h with	a D	5351 Green Bridge Road						U.	S.A.		
	ems ems	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cub	lispanic Origin?	(Specify Yes or No	0- 14.	Race - America	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 □ Never Married 2 ☆ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	<b>™</b> No		1 ☐ Yes 2 ☑ No	Specify:	erto nican, etc.)		Black, White, e	
ဂ ဂ	72 ho	eted	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usual Occup	ation	yorkina	16b. Kind	of Business/Ind	lustry
yland צוצוא	vithin ine. ihan "	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work done OO NOT use retired emaker	d)	iorking	Own	Llomo	
	Hygie Ther t	ပ္သ	17. Father's Name (First, Middle, La	st)		11011	andrer.	18 Mother's N	ame (First, Middle			
	d be ental ked o	To Be	Alexander McNei	,					ca Abern		namej	
<u></u>	shoul nd M marl	Ĕ	19a. Informant's Name/Relationship			19b. Mailir	g Address (Street				wn. State. Zin	Code)
re, Mal	nd 2 al al a 27 is rrtran		Joseph Szalecki	(Husband	(E		Green Br					
	s 1 a		20a. Method of Disposition		Tool B	( C D)	111 /01	-	Date		on - City or To	wn, State
Ĕ	Page nent c int: if		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ate Cre	stlawr dens	sition (Name of natory or other plac 1 Memoria	Î'   1-2	29-2008	Mariot	tsvill	e. MD
baltimor	porta porta ny Inju		21. Signature of Funeral Service Lic	ensee	45 4							
	89 5 8 9		Lebece C	1	> MUI.	283 5	Name and Addre Vitzke Fu 555 Twin	Knolls	Road Co	jumbia	a, MD 2	1045
			23a. Part1. En er the diseas or co shock, or heart failure Lat on	mplications that du y one cause on eac	sed the death h line.	n. Do not ente	er the mode of dyir	ng, such as cardi	iac or respiratory a	ırrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	36.4		10	10 My OP					Onset and Death
*	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	-	/				941113
	Lxammer	۰	Sequentially list conditions,	b								
	ist 🎉 🖫	nine	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	de a consequ	lende of):						
	ificate be executed by physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequ	uence of):						
00/00	be e sician buria											
00	tificate ig phys as the	ledical		d								
Š	7 000		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf <u>pr</u> egna					23d	Date of deliver	nv.
<u> </u>	death e atte d for	Physician/N	in the past 12 months?  1 ☐ Ves 2 ☑ No  1 ☐ Ves 2 ☑ No				′	Month			Day Year	
j.	t the by the tache	hys	9 □ Unknown	9 Unknow	n							
ה ה	sician: The law requires that the death cer certificate has been signed by the attendir rector, page 2 should be detached for use	by P	Part II. Other significant conditions		h but not resu	lting in the ur	derlying cause give	en in Part I.	23e. Did 1	obacco use o	contribute to the	e cause of death?
Solds,	equire en siç ould b	Completed b	BREAST CAT	CER					. 10	Yes 2∐N	2 No 3 Probably 4 Unknown	
ט ט	law r as be 2 sh								24a. Was		4b. Were autop	sy findings available
_	The ate h	ĕ							- auto perfo 1□ Yes	ormed? 2.20 No	death?	pletion of cause of
2	ctor,	Bec	25. Was case referred to medical examiner?					26. Place of Do	eath (Check only o			
5	tending Physician; The eath.  tor: After this certificate hat the funeral director, page	၉	1 ☐ Yes 2DONo	Hospital: 1 ☐ Inp		ER/Outpatien		4 🗆 Nursing	Home 5 TResi	dence 6 🗆	Other (Specify	)
ĺ	ing F	ë	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Injur Work		28d. Describe	how injury oc	curred	
2	ttend leath. tor: / the f	cati	2 Accident investigation M 1 Yes 2 No									
	or Al	Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 See. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Run City or Town, State)					ımber or Rural	Route Number,			
-	spital ours a heral filled	2	29a. Certifier 1 CertifyIng F	hysiclan: To the be	est of my know	vledne death	occurred at the tin	ne, date and pla	co. and due to the	201100(0) 222	1	
	To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; p.	edical	(Check only 2 Medical Example)	amlner: On the basis	s of examinat	ion and/or inv	estigation, in my o	pinion, death oc	curred at the time,	date and pla	ce, and due to	the cause(s)
	To th To th Somp	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sig	ned (Month, E	Jay, Year)
	/		1 1150	20	)	age of the second	7/2	4395			My 25.	
	75		30. Name and address of person who	completed cause of	of death (Item	23a) (Type, F	Print)					
	*		DANCEUR DOBERN	MAN. M	10565	NCH	ARIJES SI	- Sun 2	- 209 B.	ALTIM	mE, mi	2120+

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 8 2008

and I

3. Registrar's Signature

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	State of Maryland / Department of Health and Mental Hygiene
1- For State	Certificate of Death

	all	1-For State Registrar Certificate C		, ,	eg. No. 2008 018				
Physici dical Exam	an/	Decedent's Name (First, Middle,Last)		2. Date of Dea Month	th 3. Time of Death Day Year				
licai Exam	mer	Roger W. Sullivan  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	Month January 2	1759 hrs 4c. County of Death				
		5127 Harford Road	Baltimore	or Beauti	To. Godiny of Death				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Und	der 24Hrs. 8. Date of Bir	rth(MM/DD/YYYY) 9. Birthplace (State or				
Director		219-22-5957 1XM 2 F 78 Y	Months Days Hours	's I Min I	2, 1929 Foreign Country) Georgia				
		Usual Residence of Decedent							
w ашу		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limit				
Aaryland 28a-f show Latonce,	ţ		timore		1 X Yes 2 No				
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 5127 Harford Road	10f. Zip Code 21214	1	0g. Citizen of What Country?				
ith the 23a c	al D			ining / Conside Van an Na	USA				
eath w items	Funeral	1 X Nover Married 2 Married Armed Forces? Unit	as Decedent of Hispanic Ori Yes, specify Cuban, Mexicar		<ul> <li>14. Race - American Indian, Black, White, etc.</li> </ul>				
fter de		3 Widowed 4 Divorced If Yes, Give Year Navy 1	Yes 2 X No specify	<i>r</i> :	Specify: white				
ours a atura camin	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a. Decedential 16a.	ent's Usual Occupation (Give	kind of work done	16b. Kind of Business/Industry				
72 h an "n cal Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life, DO NOT	I use retired)	36				
Z15-0036 be filed within 7 stal Hygiene. ked other thau ent, the Medica	duc	dik -	aman		Merchant Marines				
71213-0036 Id be filed within 72 fental Hygiene. narked other thau '	Be C	17. Father's Name (First, Middle, Last)  William Estes Sullivan		er's Name (First, Middle, I	, allie				
Z 1Z 13-0030 uld be filed within 72 Mental Hygiene. marked other thau c event, the Medical	To B	19a Informant's Name/Relationship (Type Print.) 19h Maili	Luc ng Address (Street and Nur		mber, City or Town, State, Zip Code)				
Darith 1015, MD 21213-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mendal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fish injury or other traumatic event, the Medical Examiner must be notified at once		Morth R Horo/Sigtor	•		California 92399				
رم ا and Heaft Fitem		20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City or Town, State				
rmit. Pages 1 ar partment of Her portant: If ite		Tentoval non otate	<b>Crematory</b>	2-4-08	Baltimore, Maryland				
permit. J Departm Importa Injury o		- Bollation 221 One Specify. 111 Scale			pel 6009 Harford Rd.				
III D P C		Semme III all Ba	itimore, MD	<del>21201</del> 2121	L				
hysician		23a. Rart I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as o	cardiac or respiratory arr	rest, shock, or heart Approximate Interval Between Onset and				
/Medical xaminer		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Di	sease		Death				
		or condition resulting in death)  Due to (or as a consequence of):							
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
_	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated C							
ecuted and - transit	Exa	events resulting in death) Last Due to (or as a consequence of):							
execu an and al - tra	cal	UNPENDED 11,12,15-22 per fh g876 2-11-08 vt 9 per fh g876 2-25-08 vt							
r <b>oU,</b> cate be executed physician and the burial - transi	Medical	9 per fh g876  IF FEMALE: 23c. If yes, outcome of pregnancy	2-25-08 vt		23d. Date of delivery				
death certificate at the attending p		23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopi	ic pregnancy	Month Day Year				
that the death certifined by the attending detached for use as the	Physician/	4 Pregnant at time of 5	Other (Specify)		ĺ				
the de	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in P	Part I 23e Did to	obacco use contribute to the cause of death?				
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If Wiscian: The law requires that the flat this certificate has been signed by neral director, page 2 should be detach	Completed			24a. Was	an   24b. Were autopsy findings availab				
law r has b e 2 sh	du			autop	prior to completion of cause of death?				
cian: The law certificate has ector, page 2 s	S	OF Was arranged to the Land	00.01		2 No 1 Yes 2 No				
ysician: his certif director,	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death		Residence 6 V Other: Scene				
ding Physic After this funeral dir	<u>۱.</u>	1 ✓ Yes 2 No Impatient 2 Errouiparter  27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of			how injury occurred				
ath. pr: A	ţi	Natural 5 Pending	1 Yes 2	No					
tal or Attendii rs after death. ral Director: / led in by the fu	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office bullding, e		Street and Number or Rural Route Number, Cit				
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e Hos 124 ho e Fun etely	<u></u>	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated.			and place, and due to the cause(s)				
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)				
		calment !	O.C.M.E.		January 22, 2008				
		30. Name and address of person who completed cause of death (tem 23a)	on Street Baltimans	MD 24204					
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Pe 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nn Street, Baltimore, I	IVID 2 1 2 0 1					
51	ate	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	A.F.						
Regist		IAN 2-8 2008	2.0						
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08-00405 A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lbert Stanley	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar  Certificate of Death  Reg. No.									
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	. Date of Death	ay Year	3. Time of Death 0655 hrs						
<i>2</i>	4a. Facility Name (if not institution, give street and number) Union Memorial Hospital  4b. City, Town, or Location of Death Baltimore		4c. County of Death							
Funeral Director	219-40-5928 1X M 2 F 60 Yrs. Months Days Hours Min.	8. Date of Birth(N May 16,	MM/DD/YYYY) 9. Bir Foreig 1947 Co							
nd bow any ce.	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 X Yes 2 No							
3 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show any al Examiner must be notified at once. leted by Funeral Director	10e. Street and Number 418 E. 20th Street 21218	10g.	Citizen of What Cou	tizen of What Country? USA						
or items must be Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S., Armed Forces? Unk If Yes, specify Cuban, Mexican, Puerto R		14. Race - Amer White, etc. Specify: blace	ican Indian, Black,						
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner O Be Completed by I	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	ork doneunk 16								
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical To Be Comple	unk     unk       17. Father's Name (First, Middle, Last)     18.Mother's Name (First, Middle, Last)       Sterling Albert Jr     Floren	First, Middle, Mai	,	al						
MD 2 nd 2 shou slith and N m 27 is n aumatic	19a. Informant's Name/Relationship (Type, Print)  Sterling Stanley/brother  19b. Mailing Address (Street and Number or Ru 5007 Govane Avenue Bal	ral Route Numbe Ltimore,l	r, City or Town, State ${ m MD} = 21212$							
d	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 X Other Specify: in state  21. Place of Disposition (Name of cemetery, crematory or other place)  22. Name and Address of Facility	Date 2	Oc. Location - City or	Town, State						
Balt Balt Balt Balt Balt Balt Balt Balt	Ronald S. W. e. Director State Anatomy Board Baltimore, MD 21201  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or regilure. List only one cause on each line.		Street  Approximate Interval Between Onset and							
/Medical :aminer	Immediat Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease or condition resulting in death)  Due to (or as a consequence of):			Death						
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated									
0, the executed sician and courial - transit edical Exa	Due to (or as a consequence of):  d.  X UNPENDED  AMENDED									
). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transil Physician/Medical E>	#234,P11,27,perrit,8673, 1/29/05 11  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  #234,P11,27,perrit,8673, 1/29/05 11  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	су	23d. Date of deliver Month	y Day Year						
S, P.O. E uires that the d n signed by the Id be detached ed by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel by Physel	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Narcotic and cocaine use	1 Yes		bably 4 Unknown						
Records, The law requires ficate has been sig page 2 should be Completed		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of						
f Vital Physician: ar this certi ral director To Be	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 2 1 Yes 2 No		sidence 6 Other	er:						
Division ospiral or Attending nours after death. filled in by the function: After Control of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of t	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre or Town, State		ural Route Number, City						
To the Hos within 24 h To the Fun completely	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and done one of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the place of the	the time, date and	d place, and due to th	ne cause(s)						
	29c. License number  O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a)		9d. Date signed (Mc							
State	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120  31. Date filed (Month, Day, Year)  32. Registrar's Signature	1		· · · · · ·						
Registrar DHMH 17 Rev 1/2001	JAN 2 8 2008 Assure A GORIGINAL									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Attend #5,20a-c &22 Per III 08/5 1/30/08 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 250 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** dalls town WRIG Ligrose So212-56-5795 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 5, 1949 Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 😿 F Hours 58 Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified MD 1 ☐ Yes 2√ No Baltimore Randallstown Director Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-uny or other traumatic event, the Medical Examiner must be notift uny or other traumatic event, the Medical Examiner 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9119 Liberty Road 21133 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 administrative assistant SSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Leroy Smith Esther Downing ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Linda Pretlow/cousin Garobe Court Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Wurial 2 □ Cremation 3 □ Removal from State Department o Important: If any injury or 4 Donation 5 ₩ Other (Specify) in state King Memorial Park 1-30-2008 Woodlawn.Md. 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility State Anatomy Bo Wylie Funeral Hone Baltimore, MD 2120121133 9200 Liberty Rd. Randallston Md 23a. Part Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cuse (Final disease or condition resulting in death) **Physician** Du to (or as a cons. quence f) /Medical Examiner sift tissue infections Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attending Parties of the death.

I Director: After to in by the funera 1 Natural 2 Accident Injury 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Janu 19, 20: f

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month el 4a. Facility Marie (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Future Care Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 DF Months Hours 89 228-10-5837 9-18-1918 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1607 Carswell Street 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade N/A Domestic J.H.H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Billy Short Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delcina Spence - Niece 1607 Carswell Street Balto, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1-28-2008 Balto, MD Carmel Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East > Estape Mish 1101 E. North Avenue MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oblaste wool disease or condition resulting in death) Due to (or as a consequence of) Enentre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

Show

or items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a-f shown in items 23a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or 28a or

other traumatic event, the Medical Examiner

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item 27

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any injury once.

Pages 1 and 2 should be 1 nent of Health and Mental

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Be

Certification: To

Completed by Physician/Medical

signed by the attending physician and d be detached for use as the burial-transit peen this certificate completely tilled in by the tuneral after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE:
23b. Was decedent pregnan
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗆 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		105	21
24a.			
	auto perfo	psy ormed	1? /
1 🗆 Y	es	2	No

a. Was an	24b.	Were au
autopsy		prior to o
performed?		death?
Yes 2 40		1 🗆 Yes

topsy findings available ompletion of cause of 2 No

23. Was case reletted to medic	dli		heck only one)	10)						
examiner? 1 Tes 2 100	H	ospital:	2 🗆	ER/Outpatient	3 🗆 1	DOA Other:	Nursing H	ome	5 Residence	6 ☐Other (Specify
27. Manner of Death 1 □Natural 5 □ Pend	ina	28a. Date of Injury (Month, Day Ye	ar)	28b. Time of Injury		28c. Injury at Work?		28d	Describe how inj	ury occurred
	tidation				M	1 Yes	2 No			

2 Accident investigation 6 Could not be 3 Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

308

29b. Signature and title of certifier

29c. License number 31464 MD

St

29d. Date signed (Month, Day, Year) 1125

Balt. M1) 2120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FW A 1 3 A + A 1 6 M , 8 2 ( N . EU kw

1 maps 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral L

Medical

29a Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State amend #19a Per FH G876 2/05/08rtifficate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Zyth **Physician** Month Year FRANK **SCHERBA** ,2008 3.50 P M Ja vive. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anna 2007 Isninit Baltimore-Washington Med. Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year f Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** 1 M M 2 □ F Months Days Hours Min 217-20-7888 79 Director Maryland Jan. 28,1928 Usual Residence of Decedent 10c. City, Town or Location items 23a or 28a-f show ner must be notified at 10d. Inside City Limits N/A Director Maryland Baltimore 1 KYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a dical Examiner must ! 3712 Eastwood Drive 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 □ No 3altimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 🗷 No þ Specify 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Letter Carrier U.S. Postal Service nt of Health and Mental Hygie If item 27 is marked other 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Maryla.

Commit. Pages 1 and 2 should be a Department of Health and Mornants if them 27 any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury or any Injury o Szczerba Marv Kos Sylvester 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis S. Scherba 657 Riverside Drive, (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemeterv 1 - 28 - 084 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 21. Signature of Furreral Service License McCully-Polyniak Funeral Home P.A. <u>3204 Mountain Road, Pasadena, Maryland 21122</u> 23. art1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in death) Physician mon so /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be exect Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 23 cm 1 🗌 Yes 2 □ No Probably 4 □Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an Vital 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA o After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending Natural (Month, Day Year) 5 ☐ Pending investigation I hours after death. 2 Accident 1 Yes 2 🗌 No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 THomicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1008 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 28

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	/Medi Examir			City, Town, or Location of Death		4c. County of Death							
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	Funeral			Inder 1 Year If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birth	nplace (State or Foreign untry)						
	Director		Usual Residence of Decedent		Feb. 15,1	951   Mar	ryland						
	rylanc how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits						
	ne Ma 8a-f s	Director	Maryland Anne Arundel Glen I	ournie			1 ☐ Yes 2 KNo						
	with the			f. Zip Code	10g.	Citizen of What Cou	untry?						
	ns 23 must	Funeral	443 Rogers Avenue  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I	21060	ogify Voc or No	U.S.A.	ican Indian						
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 ₹ No	Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto es 2 No Specify:	Rican, etc.)	Black, White							
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Maryland	iges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 is marked other than "natun or other traumatic event, the Medical	To Be	Carmen Delbert Smith	į.	e (First, Middle, Maid Len Cathe	,	Bee						
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Baltimore,	ages ent of tt: If it y or o		1 □ Burial 2 MC Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ) Bayview Cre	or other place)		Location - City or T							
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Ö	permi Depa Impo any i	1	The Stand 3200	lly-Polyniak Fu Mountain Road	ineral Hom , Pasadena	e P.A. . Marvlan	d 21122						
į,			23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximation of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and Constant of the mode of dying, such as cardiac or respiratory arrest, Interval Be Onset and										
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	李明三十二	Jer	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury	108			1 mothers						
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Division or Vital Records,	or At after d Direc in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Street a City or Town, Sta	and Number or Run ite)	al Route Number,						
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	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ann Maga HE Ster MP 301	H = 7 1.	161	2	100						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month NATALIE SILVER January 5:00  $A^{\mathsf{M}}$ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛛 F 213-32-3391 Usual Residence of Decedent Director 10/01/1935 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f sho MD BALTIMORE BALTIMORE 1 ☐Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a c 7209 VALLEY COUNTRY COURT 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE ş Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. SECRETARY NON PROFIT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **ABRAHAM** NECHANKIN SADIE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL SILVER / HUSBAND tem 27 7209 VALLEY COUNTRY CT., BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State BETH EL MEMORIAL PARK 01/25/2008 RANDALLSTOWN, MD 4 Donation 5 Dother (Specify) 21. Signa ure Funeral Service Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Intracranical 5 day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner anti coaquilation Sequentially list conditions, if any, leading to limit equate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cita to (or sed in sequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ate has been signed by the attending p page 2 should be detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cctiven 24a. Was an Myelofibrusis 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. D 25. Was the referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Charac 020907 1/23/08

State Registrar 701

N. Charles St B. H. mure, Mol 2/20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$32. Registrar's Signature

NOU! 8

JAN 2 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 0 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner HIMORE Medica imure If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 X M 2 ☐ F Months Davs Hours Min Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. Count 10c. City. Town or Location 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1∭Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be 19a. Informant's Name/Relationship (Type. Print) (quartian) 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☑Burial 2 ☐ Cremation 3 Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. Rus 2222 W. North tome Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOLOCCAL **Physician** disease or condition resulting in death) /Medical Examiner 0 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner been signed by the attending physician and should be detached for use as the burial-transit the death certificate be executed TUR Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 3 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performed? 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Pres 2 No 1 D Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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State Regist<u>rar</u> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month,

D

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State Amend #1,4a-c,perMD,g875, 1/28/08 TT Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Continued To Contin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:07 M Allen E. Vein ZOOR HOU DY /Medical 4c. County of Deallaltimore Facility Name (It no institution, give street and number) 4b. City, Town or pration of Peath Examiner maxlo Date of Birth (Month, Day, Year) 03/26/1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number Sex./ 1 ☑ M 2 ☐ F **Funeral** Min Months Davs Hours MD 81 212-20-0486 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6702 MAURLEEN ROAD 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No ARMY If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married WHITE 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BROOKDALE FARMS OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ADDIS VEIN JEAN PHILIP ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6702 MAURLEEN ROAD, BALTIMORE, MD CHARLOTTE VEIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State BALTIMORE, MD HEBREW YOUNG MENS 01/21/2008 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. neral Service Licersee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that each the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9□Unknown Part the Other significant conditions contributing to death bot not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has After this certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tes 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Injury at Work? (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Rella Dana Kape Lally to 012 PL 31. Date filed (Month, Day, Year) JAN 28 32 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GREGORY VOLINSKY January 23,2008 09:44 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 05/01/1937 1 XM 2 □ F UKRAINE 218-92-1594 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD BALTIMORE TIMONIUM Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 620 STRAFFAN DRIVE, UNIT 306 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADVANCED BUSINESS Elementary/Secondary (0-12) College (1-4or 5+) MANAGER SYSTEMS 12 should be filed with and Mental Hygier 7 is marked other th Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EISENBERG RUVIN VOLYNSKY KHAYA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) متارم المعالم مير Aportant: If Item 27 is re Vinjury or oth 620 STRAFFAN DR., UNIT 306, TIMONIUM, MD 21093 ASYA VOLINSKY / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBunal 2 □ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or REISTERSTOWN, MD BALTIMORE HEBREW CONG 01/25/2008 4 □ Donation / 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signe are of Funeral Service Li 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 iphcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) +1KS **Physician** HEMORRUAGE /Medical Due to (or as a consequence of): Examiner MYELOID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 21 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 ☐ Yes 2 ☐ No 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After e Hospital or Attending I 24 hours after death. e Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 127730 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. CHALLET IT. BARTHORE, MD. cover MD.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

65-69 2. Registrar's Signature

		1 - For State Registrar	State of Ma		Certificate of				2008	01906	
Physici	an	1. Decedent's Name (First, Middle, I	_ast)				2. Date of Do Month			3. Time of Death	
/Medic	al	James Fdward Willia  4a. Facility Name (If not institution, of			4h City Town	or Location of Doct	Januar				
Examin	er		,			or Location of Deat	n	40	: County of Dea Baltimo		
Funeral		FutureCare— Cherryw 5. Social Security Number 6. 239-12-4879		e (In yrs. last birti	Reisters  hday) If Under 1 Year  Months Days		8. Date of Bi	rth ay Xear,	Q Rir	thplace (State or Foreign ountry)	
Director	1	Usual Residence of Decedent	A	ا ده	15.		10/1/1	922		140	
yland how at		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits	
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with th a or 26 be no	Dire	10e. Street and Number 3639 Waterwheel Sq	uare		10f. Zip Code	1.33		-	tizen of What Co USA	ountry?	
death ms 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		Specify Yes or N		14. Race - American Indian,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 □ N If Yes, Give Year or Dates:	10	1 □ Yes 2 No		to Rican, etc.)		Black, White Specify Afri	_{te, etc.} can-American	
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nit. Parantme  ortani Injury		4 ☐ Donation 5 ☐ Other (Special Special	Garriso	22. Name and Addre			1 Llom	Owings Mi	lls, MD		
Dep Imp any		Manday	M). (k	the	9200 Liberty					barro. Co.	
	1	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that called ly one cause on each lin	the death. Do no	ot enter the mode of dy	ing, such as cardia				Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition resulting in death)	a`		boticever	it				Onset and Death	
/Medical Examiner			Due to (or as a	a consequence o	Disease e	ad stag	.)				
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aw rec s beer 2 shou	Completed						24a. Was		24b. Were a	utopsy findings available	
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Sta Registra		31. Date filed (Month, Day, Year)			Sparks						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21, 2008 4c. County of Peath January 21 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Riche Joseph 5. Social Security Number HOSPICE 7. Age (In yrs. last birthday) 1 more 8. Date of Birth Month, Day, Year) March 2 1977 6 Sex Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Min. Mary and 218-88-208 Usual Residence of Decedent Director 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>۾</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) sah 100 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ams 19a. Informant's Name/Relationship (Type. Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is Balto. Md Ms. Konnel lerrace 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Cremator 22. Name and Address of Facility 21. Signature of Funeral Service Licensee WiNorth e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part . Inter the rease, shoulk or heart fature. L' Immediat Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician NS /Medical Due to (or as a consequence of): Examiner Kitt Sequentially list conditions, if any leading L immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of AI 11/2007 attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cocaire / heroin 24a. Was an has autopsy or Vital F 2 No ivision or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ٥ 2 ER/Outpatient 3 DOA 1 Inpatient 27. Mann of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide DIVIS 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I ÇertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of JOTISCH MN V 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 2 8 2008 Registrar

DHMH 17 Rev 1/2001

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i,			1. Decedent's Name (First, Middl						2.	Date of Dea	ath Day	Year	3. Time of D	
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	Examin	-	4a. Facility Name (If not institution	n, give street and number)			4b. City, Town, or		of Death			County of Death		
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	Funeral		5. Social Security Number 218-33-6163	6. Sex 7. Age (	In yrs. last birth	rs.	Months Days	If Under :	Min.	Date of Birt (Month, Day	y, Year)	Coul		Foreign
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	ems er mu	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Ori	gin? (Specif	y Yes or No- can, etc.)	- 1	<ol> <li>Race - Americ Black, White,</li> </ol>		
õ	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. An other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes Give		1	□ Yes 2X No	Specify:				Specify: whi	te	
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Mar	2 sho and is ma	·	19a. Informant's Name/Relations				Address (Street a						·	
	rt 27			badi / son	7	24	Tiffan	y Ct	., Gá			ing, Mo		78
altimore,			20a. Method of Disposition 1   Burial 2 □ Cremation	3 ☐Removal from State			ition (Name of atory or other plac						,	
	t. Pa tmen tant: njury		4 Donation 5 Other (		Natio		l Memor	1				ls Chur		4
g	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service	Licenses			Name and Addres							11
	are Av. 16		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caused the	ne death. Dono				<u>·</u>				Approximate	
% 1€	Pine in in in		shock, or hear failure. Lis Immediate Cause (Final	t only one cause on each line	+ V.		-						Interval Betwee Onset and De	een eath
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of	f)r	10	Dx	ive	_			<u> </u>	
	Examiner			. Retv.	Perch	to	ne Se an Gre	blec	edn	29				
şv.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	f):		1	, A.					
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1 . Chrc	mic	PC	an Gre	こし	11.	2				
Ď,	e exe sian a urial-		resulting in death) cast	Due to (or as a	consequence of	f):[/								
68/60	cate b	Medical		d										
	certifi ding se as	-	IF FEMALE:	23c. If yes, outcome pt	pregnancy						2	3d. Date of deliv	erv	
9	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal death		Ectopic pregnancy Other (specify)	′			-	Month		ear
j.	The law requires that the death c te has been signed by the attenc age 2 should be detached for us	Physician	1  Yes 2  No 9  Unknown	9□ Unknown										
1	s that ned b deta	y P.	Part II. Other significant condit	ions contributing to death but	not resulting in	the un	derlying cause give	en in Part I		23e. Did t	obacco us	se contribute to	the cause of de	ath?
Š	quire; in sig uld be	ed by								1 🗆 '	Yes 2	No 3□ Pro	babiy 4 □Ur	nknown
ပ္တ	s bee	olete								24a. Was		24b. Were aut	opsy findings av	vailable
ř	The late ha	Completed								autoj perfo 1∐ Yes	ormed?	death?	2∭X No	use of
Vital Hecords,	<b>hysician</b> : The law his certificate has b I director, page 2 s	Be C	25. Was case referred to medica examiner?	al				26. Place	e of Death (	Check only o	one)			
<u>-</u>	hysic his ce	L _O	1 Yes 2 No	Hospital: 1 ☐ Inpatient				4 AINL				6 □Other (Spec	ify)	
Ē	ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi			ime of jury	28c. Injur Worl			d. Describe	how injury	y occurred		
<u>S</u>	ttend leath. tor: / the fi	cati	3 Suicide 6 Could		. At home for	m etro		Yes 2		f Location (	Street and	d Number or Rui	al Boute Numb	ner .
DIVISION OF	or A after o Direction by	Certification:	4 ☐ Homicide determ	nined building, etc.	(Specify)	III, Stre	et, factory, office		20	City or To	wn, State)	)	ar rioute reamb	, car
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,			ng Physician: To the best of										
	ne Ho n 24 h ne Fu	Medical	(Check only 2 ☐ Medica one)	I Examiner: On the basis of e and manner state		l/or inv	restigation, in my o	pinion, dea	ath occurred	d at the time,	date and	I place, and due	to the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifit	51	111		29c. Licenso	e number			29d. Date	e signed (Month		
	1		550	>/VV	MIC	,	00	06	243	5	1	171	2008	
$\cap$	(5)		30. Name and address of persor	who completed cause of dea	ath (Item 23a) (7	Type, F	Print) / A	a.	8.	81	0	MD 9	2008	5
1			30. Name and address of person SAYED ELS.	MYYMU 971	's Signature	all	2 (50,67	wy.	NOC	~VIII	( )			
	Sta Registi		31. Date filed (Month, Day, Year JAN 1 1 2008	Region &	's Signature	1								
			J	1	- /									

DHMH 17 Rev 1/2001

08-00171 Daniel Lee Aaron

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aniel Lee Aaron	1-	State of Maryland / Department of Health  Certificate of Death	and Mental Hy		a No	200	18	nigr
Dhysisian	Re	gistrar Decedent's Name (First, Middle,Last)		2. Date of Deat		111	3. Time o	of Death
/Physician Medical Examine		DANIEL LEE AARON		Month January 6,	2008	ear	1649	hrs
	48	. Facility Name (if not institution, give street and number)  4b. City, Tow  Montgomery General Hospital  Olney	wn, or Location of Death		4c. County Montgo		h	
Formati	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	1 Year If Under 24Hrs.	. 8. Date of Bir	th(MM/DD/YY)	(Y) 9. Bi	rthplace (S	tate or
Funeral Director		577-82-0406 1X _{M 2} F 45 Yrs. Months	Days Hours Min.	July	26,196	Forei Co	gn ountry)	MD
<b>.</b>	-	sual Residence of Decedent					10d. Insi	ide City Limits
ow any	110	a. date	onsville				1 X Y	es 2 No
Maryland 28a-f show d at once. ector	<u> </u>	De. Street and Number 10f. Zip C			0g. Citizen of \	What Cou	intry?	
th the Maryland 23a or 28a-f sho notified at once.			20882		TT C	5.A.		
with the 18 23a se noti		Marital Status     12. Was Decedent Ever in U.S.     13. Was Decedent	of Hispanic Origin? (Sp	pecify Yes or No	- 14. Ra		rican India	n, Black,
or death with or items 23 const be no	1	Never Married 2 Married 1 Yes 2 X No	Cuban, Mexican, Puerto	Rican, etc.)			4 4 0	
safter or rall', o	٦ اح	Widowed 4 N Divorced If Yes, Give Year 1 Yes 2 or Dates:		and done	Specify 16b. Kind of	y: Wh		
hours natur Exam		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ing life. DO NOT use reti			artl		
136 thin 72 ne. than " edical	2		e Equipme	nt Tec	,l	ines		
5-0036 led within 72 hour Hygiene. the Medical Exan	<u> </u>	7. Father's Name (First, Middle, Last)	18 Mother's Name	e (First, Middle,	Maiden Surna	me)		
21 21 be fil rked rked	ž	Victor Peed	Patri (Street and Number or	cia Yo	ung	Cto	to Zin Coo	10)
D 21 should und Me r is man	2 1		itstone L					
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is n injury or other traumatic.	2	Da. Method of Disposition 20b. Place of Disposition (Name		Date P1	20c. Location	on - City o	or Town, St	tate
Baltimore, oemit. Pages I an Department of Hea Important: If iter injury or other transitives of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of the Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Important of Impo	1	Burial 2 X Cremation 3 Removal from State crematory or other place)	k Crem 1/	10/08	Rive	arda	ا ۵	MD
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Balt permit. Depart Import Injury	10	1 246 N.	Washingto	on ST,	Rockvi	ille	,MD	20850
Physician	2	3a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of failure. List only one cause on each line.	dying, such as cardiac	or respiratory ar	rest, shock, or	heart		een Onset and
M i al		mmediate Cause (Final disease a. Multiple Injuries					4	Death
	1	or condition resulting in death)  Due to (or as a consequence of):						
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	alca	UNPENDED AMENDED						
760 icate b physi	9 -	F FEMALE:  23c. If yes, outcome of pregnancy  3b. Was decedent pregnant in the	3 Ectopic pregr	nancy	23d. Date Mont		ery Day	Year
Division of Vital Records, P.O. Box 6876( Ital or Attending Physician; The law requires that the death certificate ara biter death. The Director: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the beautiful to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of	Physician/IM	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spec		ancy	1		22,	
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hat the	Q P	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.					Unknown
S, F puires i na sign				24a. Wa				ndings available
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ician;	e a	examiner? Hospital: Inpatient 2 FR/Outpatient 3 D	Othori	sing Home 5	Residence	6 O	her:	
of V g Phys g Phys eral di	<u>۹</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2	28c. Injury at Work?	28d. Describ	e how injury oc	curred	cion	
Sion C Attending death. extor: Af	틹	1 Natural 5 Pending Jan 6, 2008 1603 hrs	1 Yes 2 ✔ No		or cycle au			
IVISI I or Att after de Directe d in by 1	<u>  [2</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f. Location or Town	(Street and N , State) e & Tucker L	umber or	Rural Rou	ite Number, City
Hospital of 24 hours at Funeral L	Certification:	4 Homicide determined (Specify) Local Street						
Division of Vital To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the (Check only one)  Wedical Examiner: On the basis of examination and/or investigation, in my	time, date and place, and opinion, death occurred	nd due to the ca d at the time, da	use(s) and ma te and place, a	nner as s and due to	stated. o the cause	e(s)
To the within To the comple	훘L	and manner stated	c. License number		29d. Date			
io	-	Talassa	O.C.M.E.		January	y 7, 20	08	
Y	-	30. Name and address of person who completed cause of death (Item 23a)						
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 2					
Sta	ite	31. Date filed (MJAN 9), 1 1 2008 32. Egistrar's Signatur		OCME			<b>-</b> -	
Registr	ar	The second second						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

8

State Registrar

Jasem 31. Date filed (Month, Day, Year) JAN 2 8

29b. Signature and title of certifier

M.D. Union V32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

Memorial Hospital, MD

January 21, 2008

Spring 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIFW/19b perFH C875 1/28/08 WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUAK) Day **Physician** Year Louis E. - 3/24M Bolden 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Georges Lanham
If Under 1 Year If Under Prince 5. Social Security Number 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace Country) Hours 1**⊠**M 2□F Months Days Yrs 577-64-6292 Director 61 May 17,1946 MS Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Md. PG Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1380 Chillum Road "natural", or items 23a Examiner must Funeral 20783 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify ð 3 ☐ Widowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Bolden Beatrice Hamilton 19b. Mailing Aldras (Sirget and Number or Flural Route Number, City or Town, State, Zip Code) 3610 Labonia Way Springdale, Md. 20774 19a. Informant's Name/Relationship (Type. Print) et ano mu.... La Way 20774 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Dorothy Calcote/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 1/19/08 Landover, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signatule of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, Md.20746 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a seath line. Immediate Cause (Final failure Physician -espiraton disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Jepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Preumin: 9 the death certificate be executed ig physician and as the burial-trar Due to (or as a consequence of): P.O. Box 68760, StaphloGecus Aurens Methicillin Completed by Physician/Medical attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □ Ectopic pregnancy ò Month 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the a 9 Linknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was and autopsy performed?

Ves 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 🔽 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) M8D40611 30. Name and address of person who completed ca cause of death (Item 23a) (Type, Print)

SPAW, WD 8/18 GOOD LUCK ROAD 5 LANHAM, MD 20706 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN28 2008 Registrar

			For State Registrar	State of Maryla		rtment of Heat tificate of De			iene eg. No.2008	01912
	Dhyoisi	an.	Decedent's Name (First, Middle, Li	as <i>t</i> )		imouto or be		. Date of Deat	th	3. Time of Death
	Physici /Medi	cal		ERIE-HOPE BRO	WE			JAN	17 ^{Day} 2008 ^{Year}	9:00 P M
	Examir	er	4a. Facility Name (If not institution, gi NATIONAL NAVAL M			4b. City, Town, or Lo		4c. County of De		
	Funeral		Social Security Number 6.		rs. last birthday)	If Under 1 Year If		. Date of Birth (Month, Day,		place (State or Foreign Intry)
	Director		NONE Usual Residence of Decedent	7 X	Yrs.	1			,2008 MAR	
	how how	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	the Ma 28a-f s	Director	MD. CHAR	LES		LA PLAT	L'A	14	O- Citizen of Milest Co.	Y Yes 2 No
	23a or		9104 AMERIC	AN HOLLY CO	URT	10f. Zip Code 2064	16		0g. Citizen of What Cou U . S . A .	ntry ?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1   ↑ Never Married 2   ↑ Married 3   ↑ Widowed 4   ↑ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2√2 No If Yes, Give Year or Dates:		Vas Decedent of Hispa Yes, specify Cuban, ☐ Yes 2 No S	anic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: WH	, etc.
15-0	רא 27 ה "natu edical	letec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	ent's Usual Occupation kind of work done duri DO NOT use retired)	on ing most of working		16b. Kind of Business/In	idustry
2121	y withir giene. r than the Ma	Completed	Elementary/Secondary (0-12)  infant	College (1-4or 5+)		nfant			N/A	
	1 and 2 should be filed Health and Mental Hygis em 27 is marked other other traumatic event, #	BeC	17. Father's Name (First, Middle, Las				3. Mother's Name (		Maiden Surname)	
Maryland	should be nd Mental marked o	ဥ	ERIC ANDREW  19a. Informant's Name/Relationship		10b Mailin	n Addrona (Street and			ER BUNCH City or Town, State, Zij	- 0-4-1
	and 2 sealth an n 27 Is		ASHLEE BROW	,	ı				A PLATA, M	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [	Removal from State	b. Place of Dispos cemetery, cren	sition (Name of patery or other place)	Dat	e ;	20c. Location - City or To	own, State
II.	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Special Signature of Foneral Service Lice	(fy) METRO		N CREMATO		-08 A	LEX., VA.	
Ва	perm Depa Impo any i		Michael Company	M00479		Nome and Address of MOND FU	JNERAL S			
	200		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the do	eath. Do not ente	r the mode of dying, s	IARYLAND such as cardiac or i	espiratory arre	est,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ARY HYPO	PLASIA				Onset and Death
	Examiner			Due to (or as a cons	sequence of):					
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentified Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
By.	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):	11.				
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68 89		Medi	IF FEMALE:							
P.O. Box	Attending Physician: The law requires that the death certificateath or death.  ector: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 N No 9 Unknown	23c. If yes, outcome pf preed to be a control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t	etal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	res that signed by be deta	by Pł	Part II. Other significant conditions	contributing to death but not r	resulting in the un	derlying cause given i	n Part I.	23e. Did tob	acco use contribute to t	he cause of death?
ord	w require been sit should b							1 □ Ye	es 2Xi No 3 □ Prol	oably 4 ☐Unknown
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Vit	/siclar s certif lirectol	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient 2	ER/Outpatient	Othor	6. Place of Death (		e) nce 6 □Other (Specia	£.)
n or	ding Physiclan: n, After this certific funeral director,	on: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of	28c. Injury at Work?			w injury occurred	<u>y)</u>
Sio	vttendii death. ctor: A y the fu	catic	2 Accident investigatio	n		M 1 ☐ Yes	2 □ No			
Div	al or A after of Direct d in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	ecify)	et, factory, office	281	City or Town	reet and Number or Run , State)	M Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		hysician: To the best of my k miner: On the basis of exam and manner stated.						
	To th Within To th	Me	29b. Signature and title of certifier	MAD		29c. License nu		29	d. Date signed (Month,	
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			30. Name and address of person who	ompleted cause of death (II RLEY GPT MC			ATIONAL N ETHESDA M		EDICAL CENT	EK
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sig	48					
	Registr	ar	JANAGZ	JUL June 19 18 18 18 18 18 18 18 18 18 18 18 18 18	1					

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	Physic	ian			, , , , , , , , , , , , , , , , , , , ,	, Last)					Month		ay Year	3. Time of Death		
	/Medi		40		n Bui						JAN	7	- 2008			
	Exami	ner	44.			, give street and n	umber)		4b. City, Town, o			4	c. County of Death			
			E 0	500 He Social Security No	exton Hi		7 4 //-	to the father		lver Spr			Montgo			
	Funeral		5. 3			6. Sex 1⊠M 2□F		yrs. last birthday,	If Under 1 Year Months Days		Min. 8. Date of (Month)	Birth Day, Yea	r) 9. Birth	place (State or Foreign intry)		
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	land w		_	. State	10b. County		100	c. City, Town or Le	ocation					10d. Inside City Limits		
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	with with	Ö	108						10f. Zip Code			10g. C	itizen of What Cou	ntry?		
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an	12 should be filled within 'n and Mental Hygiene.' 7 is marked other than "raumatic event, the Merce	Be C				,				10. 14/0(1/0) 3			m Sumame)			
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Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryian of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. In Medical Examiner must be notified at		100										or Town, State, Zij			
	1 and Health Bm 27 ther tr	113	202	Dat Bui - Son 500 Hexton Hill Drive, Silver Spring, Maryland 20904  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State												
ō	Pages 1 nent of H int: If ite iry or ot			1 ☐ Burial 2 ②	Cremation	3 Removal from		cemetery, crei	natory or other place	e)	Date	20c. L	Location - City or I	own, State		
ij	t. Partmer		'4 Donation 5 Other (Specify) Fort Lincoln Crematory 01/14/2008 Brentwood,											ryland		
Baltimore,	permit. Pages 1 and 2 of Department of Health ar Important: If Item 27 is any injury or other trau QDCs.		21.	Signature of Fun	eral Service L	Licensee		Hi	Name and Address nes-Rinaldi	l Funera						
			23a	a. Part 1. Enter th	e disease, or	complications that	caused the	death. Do not ent	800 New Har	npshire .	Avenue, Si	Iver S	pring, Mary	/land 20904 Approximate		
	M F L	23a. Rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final												Interval Between Onset and Death		
	Fnysician /Medical		dise	ease or condition ulting in death)		a		MENTIA								
	Examiner					Due to	_	nsequence of):	A = 0 A	- 0						
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/ita	Phyelclan: Th this certificate ral director, pag	Be		Was case referre	ed to medical					26. Place of	Death (Check on)					
=	hyel his c	2		I ☐ Yes 2XN	10	Hospital: 1 🗆	Inpatient	2 ER/Outpatien	t 3 DOA Othe	ar: 4 🗆 Nursir	ng Home 5XR	sidence	6 Other (Specify	y)		
	iding Phye th. After this funeral dir	i.		Manner of Death	5 Pending	28a. Date (Mon	of Injury oth, Day Yea	28b. Time of Injury	28c. Injury Work	at ?	28d. Describ	e how inju	iry occurred			
Sio	Attending r death. ector: After by the fune	ati	2	2 Accident	investiga	ation				res 2□No						
Division	if or Attend after death Director: /	Certification:		3 🗋 Suicide 4 🗋 Homicide	6 Could no determin	and 288. Place	e of Injury - / ling, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location	(Street ar Town, State	nd Number or Rura e)	l Route Number,		
	Ital o	Se										,	-,			
	Hospital 24 hours a Funeral C	edicai	29a.	Certifier 1 (Check only 2	Certifying	Physician: To the	a best of my	knowledge, death	occurred at the tim	e, date and p	lace, and due to the	ne cause(s	and manner as st d place, and due to	ated.		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edi				and man	iner stated.	mination and/or my	estigation, in my op	mnon, death c	occurred at the tim	e, date an	d place, and due to	the cause(s)		
	To the within 2 To the complet	Σ	29b.	Signature and ti	tle of certifier				29c. License				ate signed (Month,			
ŧ	1				HI_	MD			DS	4486		JA	NUARY	9,2008		
	1		30. N	lame and addres	ss of person w	no completed caus	se of death (	(Item 23a) (Type, I	Print)	-						
_			]	Huyanh Th	at Ton,	M.D., 7505	New Ha	mpshire Av	enue, Suite	310, Ta	akoma Park,	Mary:	land 20912			
	Sta		31.	Date filed (Month		32.	egistrar's Si	ignature	-							
	Registra	ar		JA	N 10	2008	Muse	H A	التابا							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier (e) 1 - For State Registrar Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BRAND Day Jonhany Year **Physician** argaret. 2-25PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year It Uniter 24 Hrs. 8. Date of Birth (Month, Day, Year) izw (Dursin CUETO Dunty 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 3 F Yrs. Director 217-76-6596 97 1910 Kentucky Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic avent, the Madical Examination of the formal section of the madical Examination of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of the formal section of 1 ☐ Yes 23€ No Directo Frederick Maryland Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA 12 Hamilton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2☐ No Specify: White þ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is markad othar than "na Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene W. Bailey Wade W. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. 15 Caroline Avenue, Felton, DE 19943 Sharon V. Buley/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 12, 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of F neral Service Ucensee 22. Name and Address of Facilit Francis J. Collins Funeral Home Inc. Mehad I Hales 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line.

Approximate onset and Death Immediate Cause (Final disease or condition resulting in death) Acule Pnysician Rend Failure One week /Medical Due to (or as a consequence of): Examiner وبعدي Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (fr as a consequence of): the attending physician and hed for use as the burial-transit OSTeomyelito weaky that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 pe IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. DEMENTIA ALZHEIMER'S 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed BROTHRITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 2 1 No 2 No 1 Yes 1☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attanding Pl 24 hours after death. a Funaral Director: After ti Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number B. Jan yary D,30469 # 308 COLUMBIA, MD.21045 and address of person who completed cause of death (Item 23a) (Type, Print) VELLANK, 8850, CoLYMBIA 100 OC PARKWAY

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 1 0 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registra AVEND#20b, open				artment of H		d Mental H			01015	
		17.6	Registra A PENDH200, Quel      Decedent's Name (First, Middle, La		טטיו,יעיו	061	lineale of I	Jeani	2. Date of D	Reg. N	°·2008	3 Time of Death	
	Physic		Caroline M.						Month	Da	ay Year	5:29 pM	
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	Examir	ier	Holy Cross Hos		/			ver Spri			Montgo	norv	
÷.	Funeral		5. Social Security Number 6. S		ge (In yrs. la	st birthday)	If Under 1 Year	If Under 24 F	rs. 8. Date of B	irth	9. Birthp	place (State or Foreign	
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	D		Usual Residence of Decedent							_ ,,_			
	how	_	10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits	
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	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	10g. Citizen of What Country?		
	ath w		505 Scott Dri	т				20904			U.S.A		
	er de Items	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ın, Mexican, Pı	' (Specify Yes or Nuerto Rican, etc.)	ło-	<ol> <li>Race - Americ Black, White,</li> </ol>		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifiled at		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:			1∐Yes 2ÖNo	Specify:			Specify: W	hite	
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ary	shou	Г	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (Street a	and Number or	Rural Route Num	ber, City	or Town, State, Zip	Code)	
Σ	and 2		Garth Burleyson - 1	Husband		505 S	cott Drive,	Colesvi	lle, Maryla	and 20	904-1067		
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	1D	1 001	ce of Dispo	sition (Name of matory or other plac	e)	Date	20c. l	ocation - City or To	own, State	
Ĕ	Page nent ant: Il		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			Linco	oln Crema	tory 01	/14/2008	Bren	twood, Ma	ryland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trau		21. Signature of Funeral Service Lice	ee		22	2. Name and Addres	ss of Facility				-	
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			23a. Part1. Enter the disease, or com shock or heart failure. List only	diac or respiratory	arrest,		Approximate Interval Between						
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	/Medical		resulting in death)	a	s a conseque	ence of):					_		
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9	leath certific attending p		IF FEMALE:	220 Maria cutaam									
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal d	death 3□	Ectopic pregnancy			1	23d. Date of deliver Month	ery Day Year	
0	ires that the de signed by the a be detached	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of dea	atn 5L	Other (specify)					,	
4	that the by detac		Part II. Other significant conditions of	contributing to death	but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to the	ne cause of death?	
Vital Records,	signe d be	l by		3		3	, , ,		1 [	Yes 2	2□No 3□Prob	pably 4 ⊠Unknown	
Ö	w requir been s should	Completed				_							
Rec	has ye 2	ld m								s an opsy formed?	prior to col death?	psy findings available mpletion of cause of	
a									1□ Yes	2 🗓 N		2 □ No	
Z:E		Be	25. Was case referred to medical examiner?	Hospital: ,			t 3 DOA Othe	2F.	Death Check onl				
o	Phys rthis raldi	-T	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 ☐ Inpat		R/Outpatien 28b. Time of	1 3 DOX	4 LI Nursin	g Home 5 ☐ Res 28d. Describe		6 ☐Other (Specif	y)	
on	ding F h. After funera	ion	1 ☑ Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	Work	(? Yes 2 □ No	20d. Describe	r now inju	ary occurred		
Division	I or Attending after death. Director: After I in by the fune	fica	3 Suicide 6 Could not be	28e. Place of in	ijury - At hom	ne, farm, str	eet, factory, office		28f. Location	(Street a	nd Number or Rura	I Route Number	
Ω	in the	Certification:	4 ☐ Homicide determined	building, e	etc. (Specify)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	own, Sta	te)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in In		29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowl	ledge, death	occurred at the time	ne, date and pl	ace, and due to th	e cause(	s) and manner as s	tated.	
	e Ho 24 F e Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis and manner s	of examination	on and/or in	vestigation, in my o	pinion, death o	ccurred at the time	e, date ar	nd place, and due to	the cause(s)	
	Nithin Nomp	Me	29b. Signature and title of pertifier	01			29c. License	number		29d. D	ate signed (Month,	Day, Year)	
	2		I the 1	1 5			D 20	1348			1.0	9.08	
	)		30. Name and address of person who		death (Item 2	23a) (Type,		-					
				erman huy	•	, , , , ,	Glen Road, S	Silver Sp	oring, Mary	land	20910		
κ	Sta	ite	31. Date filed (Month, Day, Year)		trar's Signatu	re	Serio						
	Registr	ar	JAN 11 200	18 Bears	J.K.	400	W.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 6:45 P M 9, 2008 Morris Blanco January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)
 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 578-46-8603 New York April 30, 1920 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, th- Me Itcal Examiner must be notified at Rockville 1 X Yes 2 No Director Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21 Shagbark Court 20852 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No Army
If Yes, Give
Year or Dates: WW 2 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 3 Widowed 4 Divorced WW 2 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Furniture Years Owner and Merchant 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ezra Blanco Sadie Ades ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Shagbark Court, Rockville, Maryland 20852 Elvira Z. Blanco - Wife permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Garden 1/11/2008 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Edward SAgel Funeral Direction, Inc. tottlemen 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC LUNG DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse guence of Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No death? 1 ☐ Yes 1∐ Yes 2∏ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

USHA GOLLAPALLI, 6121 MC

1 1 2008

32 egistrar's Signature

usha

31. Date filed (Month, Day, Year)

JAN

D0061096

6121 MONTROSE ROAD ROCKVILLE, MD 20852

01/10/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Ralph Wayne Biggs Jan 18, 2008 9:10 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 22311 Westernport Road, Allegany SW Westernport
If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1X M 2 ☐ F Director 10/03/34 <u>220-32-2745</u> MD Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Allegany 1 ☐ Yes 2 ☐ No Westernport 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22311 Westernport Road, SW 21562 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1√Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 3 ☐ No Specify Be Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u> 12th</u> <u>boiler operator</u> <u>Pulp & Paper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph P. Biggs Margaret Wilkinson မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Biggs/wife 2311 Westernport Rd., SW, Westernport, MD 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Philos Cemetery 1/22/08 4 Donation 5 Other (Specify) Westernport, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markwood Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** upplotose /Medical Due to (or as a cons vuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to jui burial-transit Due to (or as a consequence of): Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 1□ Ýes 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

and

physician

by

certificate I

this

After

24 hours after death Funeral Director:

Hospital

Baltimore, Maryland 21215-0036

within 2 10

State Registrar

29a. Certifier (Check only one)

29b. Signature and tille of certifier

537 S. Mineral Zalzal, MD, Rabie 32 Registrar's Signatur

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

mD 1651

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan 19, 2008 **Physician** Bland 6:20am Leota /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Living Center of Cumberland Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X Mar 20, 1918 220-10-1264 89 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Cumberland 1 XYes 2 No Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 512 Winifred Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ 🖟 Specify þ Specify. 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurses Aide Hospitai 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic ever Herman Derlan Rose (Riggleman) Derlan 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 525 Winifred Road Cumberland MD 21502 Betty Shipley 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □Xurial 2 □ Cremation 3 □ Removal from State Hillcrest Memorial Park 1/22/2008 23. Name and Address of Facility
Scarpelli Funeral Home, PA
108 Virginia Avenue: Cumberland
23. Str. Enter the disease of convilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limit diate Cause (Final disease or condition resulting in death)

a. MD 4 ☐ Donation 5 ☐ Other (Specify) Cumberland 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Due to (or as a consequ-nce of): **Physician** YM /Medical Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a nonsequence of Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ² 2 ER/Outpatient 3☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of cert 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, completely filled in by the funeral director, To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

Registrar DHMH 17 Rev 1/200

3

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 25

31. Date filed (Month,

m.D 32. Registrar's Signature DOU33280

GAS KENT AVE CUMBERUTNO, MD 21302

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** 11:25 AM 20, V. Bean Carole Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Allegany** Sacred Heart Hospital Cumberland 8. Date of Birth (Month, Day, Year)
Dec . 22, 1941 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Securify Number **Funeral** Months Days Hours 1□M 2**X**F 66 Director 291-48-0993 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XNo Director WV Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 1063 26704 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Housekeeping Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edress C. Bissett William Blackburn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Lawrence Bean Jr. (husband) <u>P.O. Box 1063</u> Augusta, WV 26704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/23/08 4 Donation 5 DOther (Specify) Mt.Dale Cemetery Shanks, W 21. Signature of Funeral Service Licens 22. Name and Address of Facility McKee Funeral Home Inc. P.O. Box 270 Augusta, WV 26704 ames 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician -UNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown icate has been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) dire 1 ☐ Yes 2 **1**0 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 124 hours after death.

Pe Funeral Director: A bletely filled in by the fu 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To th. within 2. and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

2

State Registrar 31. Date filed (Month, Day,

25

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMORIAL AVE Comberland, ND 21502 M.D. 50 2. Registrar's Signature 500

D54411

20 2008

		1- For State Registrar			Certif	ficate of	Death				Re	eg. No.	٠ د	<i>)</i> (		1 1 4	
Physic		Decedent's Name	(First, Middle	e,Last)			2.	2. Date of Death  3. Time of Death									
ledical Exam		Eliza	abeth	Lo	uise	Ca	arder			Month Day Year 1413 hrs January 19, 2008							
		4a. Facility Name (if		n, give street and no	umber)							4c. County of Death					
		14 Euclid Pla			Cumberla	and				Allegany							
Funeral		5. Social Security Nu	umber	6. Sex	7. Age (In vrs. last	Age (In yrs. last birthday) If Under 1 Year If Under 2				24Hrs.	8. Date of Bir	th(MM/DD	ryyy	9. Birth	olace (Stat	e or	
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f show all Examiner must be notified at ones.	ä	14 1	Euclid	Place			502				USA						
with with be no	Funeral	11. Marital Status		cedent Ever in U.S.						cify Yes or No	- 14.	Race -		an Indian, l	Black,		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is nameded other than Important: If item 27 is nameded other than impury or other transmatic event, the Medical	1	Nancy E.	Carde	17½	17½ Valley St, Floor					Cumberland, MD 21502							
and and fealth		20a. Method of Disp	osition		20b. Pla	ce of Disposit	ion (Name o				Date		20c. Location - City or Town, State				
ges 1 t of 1 : If i		1 X Burial 2	Cremation	TOTA State	matory or other	2/2009	07.	Oldtown, MD									
ti Pa tmen tmen		4 Donation 5 Other Specify: Oldtown Cemetery									-					P A	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite		22. Sign ture of Funeral Service vicensee  22. Name and Address of Facility Adams Family Funeral Home															
	-	23a. Rart Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval															
Physician /Medical		failure. List only one cause on each line.											Onset and				
xamine		Immediate Cause (Final disease a. Diabetic renal disease Death															
		or condition resultin	g in death)	Due to (or as	a consequence of):												
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Division tal or Attendii rs after death. al Director: A	Įį.	3 Suicide	P	d not be	ce of Injury - At hom	e, farm, stree	t, factory, off	ice bu	uilding, et	c. 2	8f. Location (		Numbe	r or Rur	al Route N	lumber, City	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide		mined (Specify	)						or Town,	State)					
Hosp 34 hou Funer ely fi		29a. Certifier	Certifying Ph	nysician: To the be	est of my knowledge,	, death occurr	ed at the tim	e, dat	te and pla	ice, and d	ue to the cau	se(s) and i	manner	as state	d.		
To the I within 2 To the I complet	Medical	one) 2	Medical Exar	miner:On the basis	of examination and	/or investigati	on, in my opi	inion,	death oc	curred at	the time, date	and place	, and di	ue to the	cause(s)		
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	30. Name and a dress of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Madical Examiner 111 Penn Street, Baltimore, MD 21201																
					F But	A.a.	an Suee	., Da	au noi e	, WID Z	1201						
Regis	state	31. Date filed (Monti	AN, 2 an 8	2008 325	Régistrar's Signature	0	J-										
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ן ק מ	nf Health and Mental Hygiene. Rem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	,		20b. Place of I	Disposition	Name of	1	-	Date			or Town, State	
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			23a, Part1. Enter the disease, or	complications that	caused t	he death. Do no		<b>Universit</b> e mode of dying					ng, MD 2	Approxim	
D.			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line									Interval B Onset and	etween d Death
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amend #20b Per FH G880 6,30,08 JH Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ARCHIE BOLDER CONWAY JR. JANUARY 2008 10:42 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 10000 Brunswick Avenue, Apt. 221 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1**X** M 2□ F 579-38-1803 76 Yrs. Director December 4, 1931 District of Columbia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits rthan "natural", or itama 23a or 28a-f ahov tra Medical Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10000 Brunswick Avenue, Apt. 221 20910 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Anned Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ If Yes, Give KOREAN Year or Dates: KOREAN Specify: Specify: 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Library of Congress permit. Pages 1 end 2 should be filt.
Department of Heelth and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archie Bolder Conway, Sr. Marian Cecelia Crosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nannie J. Monk, Cousin 3202 Orleans Avenue, District Heights, Maryland 20747 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/15/2008 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 01/18/2008 Cheltenham, Maryland 21. Signature of Funeral Service Lice once Hines-Rinaldi Funeral Home, Inc. manda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** CONGESTIVE HEART FAILURE resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events **CARDIOMYOPATHY** Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, CHRONIC OBSTRUCTIVE PULMONARY DISEASE 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed? has certificate 1 ☐ Yes of Vital 25. Was case referred to medical examiner?

140 Yes 2 

No To Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours effar death. To the Funeral Director: After th completely filled in by the funeral 27. Minner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification; 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Medical 29a Certifiet one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) annel MD# 0101233709 **JANUARY 9, 2008** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL E. HERMAN, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 1 2008

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #10b Per FH G075 1731 / 08 Jh

Certificate of Death Reg. No. 1 - For State Registrar Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 8:15 AM 23, 2008 Donald Bay Coulter, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Harford Memorial Hospital Havre de Grace | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 9, 16 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**⊠**M 2□F 1927 80 219-16-5624 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director Cecil Harkord Port Deposit 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21904 u.s.A. 11 Circle Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Mayes 2 No Il Yes, Give Year or Dates: 1944-46 1 Never Married 2 ☐ Married 1 ☐ Yes 2 M No Specify: Baltimore, Maryland 21215-0036 Specify: Completed by White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h is marked of Beulah B. Watters Howard L. Coulter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Ia m any Injury or other traum once. Aberdeen, Maruland 21 001
Date 20c. Location - City or Town, State 709 Nottingham Drive, Donald B. Coulter, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Angel Hill Cemetery 101/28/2008 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. Sispature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Immediate Cause (Final disease or condition resulting in death) aa **Physician** /Medical Due to (or as a consequence of). Examiner Obalcio Esquentially life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Ma WIG Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #4a Per Phy G875 2/01/08 JH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Carol French Creswell 20, January 2008 6:45 A /Medical 4a. Farility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2√2 F Yrs. 95 218-46-0669 Director March 6, 1912 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Medical Examiner must be notified 1 ☐ Yes 2 ☐ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave. 23a 21795 U.S.A. Funeral filed within 72 hours after death 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ş 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic. Elementary/Secondary (0-12) College (1-4or 5+) 4 Page Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert A. French Ada Stowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne C. Seibert (Daughter) 13731 Seiberts Lane Clear Spring, Maryland 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 23, 2008 Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 AVIS MO1414 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimers 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the following that indicate or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 9□Unknown Month Dav Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown aortic stenosis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ∏Yes 2 ∏No death. after death 6 ☐ Could not be within 24 hours after de To the Funeral Directo completely filled in by ti 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) Kuttner-Sands, no D47451 Cynthia January 21, 2008 Sands, MD Homewood Nursing Home, 16505 Virginia Avenue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Kuttner-Williamsport, Maryland 21795 31. Date filed (Month, Day, Year) JAN 25 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

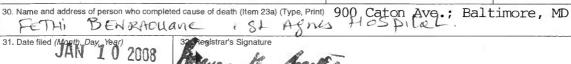
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year 29:35 M 01 07 2008 Dominga Molina de Palacios /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITEL Agnes BALtimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sev 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 12 12 F 80 Director None El Salvador July 6, 1927 Usual Residence of Decedent with the Maryland a or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Departamento 1 ☐ Yes 2 ☐ No Director El Salvador, Cuscatlan 10e. Street and Number San Rafael Cedros 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a o El Salvador Canton El Espinal Pages 1 and 2 should be filed within 72 hours after death vnent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1⊠Yes 2□No Specify: ð Specify: Salvadoran White 3√12 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Molina Venedicto Navarro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau Manuel Navarro/Nephew 6118 85th Place, New Carrollton, MD 20784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 14, San Rafael Cedros, Departamento Cementerio General de 4 Donation 5 Dother (Specify) Cuscatlan, El Salvador, CA San Rafael Cedims Address of Facility 21. Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd, West, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OlDay **Physician** Hemorrhogie /Medical Due to (or as a consequence of): Examiner Elle to for an a consequence on Sequentially list conditions, if any, bath is out to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical aftending phase as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s µerrormed? 1∐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident after death within 24 hours after dea

To the Funeral Directo

completely filled in by th 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Mosth, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>08</u> Month **Physician** Ам 1:55 Davis Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1XM 2□F Yrs. 83 1924 Oklahoma Director 447-12-0060 June 11, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23a or 28a-f show ner must be notified at 1 X Yes 2 No Director D.C. Washington, D.C. None 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 311 10th St., N.E. 20002 TISA Examiner must Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1943— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 'natural", or 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 Bureau of Alcohol, Elementary/Secondary (0-12) College (1-4or 5+) Tobacco and Firearms Director 5+Pages 1 and 2 should be filed vent of Health and Mental Hygic ant: If item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ivan Francis Davis Ruth May Nabors 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Gazzola/ Personal Department of Health ar Important: If item 27 Is any Injury or other trauonce. Rep. 1400 K St., NW Suite 1010 Washington, D.C. 20005 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Crematory 21. Signature of Fundal Service Licens 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **≭**`hysician Clostridium Dificille Colitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Sepsis Syndrome, Dysphagia, Malnutrition, 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Failure to thrive, Dementia 24a. Was an page 2 s autopsy performed? Yes 2**X** No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No P 28a Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Hospital or Attending (Month, Day Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner Records, Division or Vital

Maryland 21215-0036

Baltimore,

neral Director: /

6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D53367

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Jan. 7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 9801 Georgia Ave. Suite 117 Silver Spring, MD 20902 Rajan Shyamsundar,

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 1 0 2008



and manner stated.



within 24 hours a

To the Funeral [

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			Registrar  1. Decedent's Name (First, Middle, Last)	Oel	incate of Death	Reg. 2. Date of Death	No- O O O	3. Time of Death			
H	Physici		Leonard Nettleton ]	David			Day Year	9.05 - M			
	/Medio Examin		4a. Fecility Name (If not institution, give s		4b. City, Town, or Location of Death	January 6	6, 2008 8:05 p				
	CAGIIII		Rockville Nursing	Home	Rockville		Montgomer	v			
	Funeral		5. Social Security Number 6. Sex	14 of 5	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Ye	9. Birth	Birthplace (State or Foreign Country)			
c	Director		266-32-9951 X	78 Yrs.		Feb. 2 19	29 Mass	achusetts			
	land ow		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits			
	Mary I-f sh	Į	MD Montgomen	ry Silver Sp	ring			1 Yes 2 □ No			
	h the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?			
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36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1♥Yes 2□No IfYes, Give Year or Dates: Korean	1 ☐ Yes 2 No Specify:		Specify: Wh:	ito			
21215-0036	d within 72 hours after death with the Maryland piene. r than "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at	edt	15. Decedent's Educ	War	dent's Usual Occupation	166	. Kind of Business/Ir				
215	within 72 ene. than "ne	plet	(Specify only highest grade Elementary/Secondary (0-12)	(Give	kind of work doné during most of workir DO NOT use retired)	ng		,			
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Maryland	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Typ		ng Address (Street and Number or Rura						
	s 1 and 3 if Health item 27 other tr		Mrs. Marcia N. Dav  20a Method of Disposition	20b. Place of Dispo-	Beaverbrook Ct. #	ate Silver	r Spring, Location - City or T	MD 20906 own, State			
	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	emoval from State	natory or other place)	0./2000		****			
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			23a. Part1. En er the disease, or complice shock or peart tailure. List only on	cations that caused the death. Do not entered cause on each line.	er the mode of dying, such as cardiac o	r respiratory arrest,	<b>.</b>	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Atrial Fibrillatio				Onset and Death			
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  By Hypertension								
\$	Examiner										
	ed sit	Examiner	Sequentially list conditions, if any, leading to animodate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
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68	tifica ng ph as th	Physician/Medic					Maries -				
Вох	th cer tendin r use	an/h	23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliv				
		Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		Month	Day Year			
P.O.	ac t	Ph)		tributing to death but not resulting in the ur	nderlying cause given in Part I	23e. Did tobaco	co use contribute to	the cause of death?			
Vital Records,	8 6 9	d by	Dementia		babiy 4 🗹 Unknown						
cor	> 10 0	Completed				24a. Was an		opsy findings available			
Re	The law ate has b page 2 st	шc				autopsy performed	prior to co	empletion of cause of			
ta	ician: Th certificate rector, pag	a	25. Was case referred to medical		26. Place of Death	(Check only one)	No 1 ☐ Yes	2□ No			
<u>&gt;</u>	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2. ☑ No	ospital: 1 Inpatient 2 ER/Outpatien	Othon		6 Other (Speci	ify)			
n of	6 6 6		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at 2 Work?	8d. Describe how in	njury occurred				
sio	tendin eath. tor: Aft the fur	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No						
Division	or At lifter d Direct in by	Certification:	4 Homicide determined	28e. Place of trijury - At home, farm, stre building, etc. (Specify)	eet, factory, office	City or Town, S	t and Number or Rui tate)	al Houte Number,			
ld	ours a leral filled		29a. Certifier 1 Certifying Phys	licien: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated			
	• Hos 24 h • Fur letely	Medical		ner: On the basis of examination and/or inv and manner stated.							
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	111	29c. License number		Date signed (Month,				
, .			Gentle Just	me MD	D006462	4	01/08/20	008			
1	2+1		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type,	Print)						
			Sandeep Sharma 31. Date filed (Month, Day, Year)	10901 Connecticut A	venue Kensington,	Maryland	20895				
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DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

3altimore, Maryland 21215-0036 11500 Stewart Lane, Apt. 413, Silver Spring, MD 20904 San Salvador, El Salvador Certification: 1 🔼 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) D61887 January 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Rabin, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) edistrar's Signature State 2008 10 Registrar

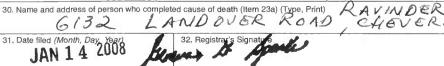
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 Day 2008 21:30 Jan. Roy Stanley Eckert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly 8. Date of Birth (Month, Day, June 3, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex Hours Days 1X M 2 T F 579-14-3056 Wash., D.C. Director 85 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any injury or other traumatic events. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12626 Blackwell Lane 20715 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Fes 2 No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2X Married 1 ☐ Yes 2 No Specify. b Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levi C. Eckert Madeline Keys 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarissa C. Eckert / spouse 12626 Blackwell Lane Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 01/16/08 Silver Spring, MD. 21. Signature of Funeral Service Ligansee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi System **Physician** days /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ionicrobial bactrainic Examine The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ & wave onyo cartlea marcher 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed molony 24b. Were autopsy findings available prior to completion of cause of death? autopsy Keker-non Insuli theteesson perform 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 . Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year) **JAN 14** 



D24720

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month SAMUEL EDLOW JANUARY 10, 2008 6:35 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5450 WHITLEY PARK TERRACE #313 **BETHESDA** MONTGOMERY 8. Date of Birth (Month, Day, Year) 08/23/1914 Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F 93 Yrs 317-10-1531 Director INDIANA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10c. City, Town or Location a or 28a-f show the notified at 10d. Inside City Limits 1X Yes 2 □ No Directo MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Items 23a o iner must be 5450 WHITLEY PARK TERRACE #313 20814 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or Item edical Examiner I Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ž No Specify Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR NUCLEAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked BARUCH EDLOWITZ မ RENA SOLOMON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is ROBERT L. EDLOW - SON 1620 EAST JEFFERSON ST. #105, ROCKVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tx☐ Burial 2 ☐ Cremation 3 ☑ Removal from State permit. Page Department of Important: If any Injury or KING DAVID MEML GDNS 4 ☐ Donation 5 ☐ Other (Specify) 01/11/2008 FALLS CHURCH, VIRGINIA 22 Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 21. Signature of Funeral Service Licensee Donald Rottlemuser 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed STROKE burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 **X**No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Ca 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 1 2008

31. Date filed (Month, Day, Year)

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JASMINE C. GATTY , MD

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	/Medi	cal						1					
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			St. Cat	therine	's Nurs	sing H	Iome	Emmi	tsburg.	MD	Fre	ederi	ick
	Funeral		5. Social Security Nur			Age (In yrs. I		Months Days		8. Date of Birt (Month, Da)	h	9. Birthp	place (State or Foreign ntry)
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show any injury or other treumatic event. I've Modical Examiner must be notified at once.	Funeral Director	44 M- 2-1 00-1		12 Was Doods	ant Ever in 111	0 10						
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			23a. Part / Shift the shock, in heart	e dy ease, or com f mure. List only	one cause on each	sed the death h line.	. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory ari	rest,		Approximate Interval Between
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of	ulng Physicien: The In. After this certificate he funeral director, page		27. Manner of Death		28a. Date of I	njury	28b. Time o		y at	28d. Describe he			
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≥	or A of A of A of A	핕	4 🗌 Homicide	determined	building,	etc. (Specify)	)	eet, lactory, office		City or Town	n, State)	er or murar	noute Number,
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	hou hou	cal	29a. Certifier 1/ (Check only 2	Certifying Ph	ysician: To the be	st of my know	rledge, deatl	occurred at the tir	ne, date and place, pinion, death occur	and due to the c	ause(s) and ma	anner as sta	ated.
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	edical	one)		and manner	stated.	on and/or m		pinon, deam occur	ieu ai ilie ilme, d	ate and place,	and due to	trie cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Grover Ford 2008 L Jan. /Medical 11:50 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Bowie Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F 91 231-14-9148 Director ug, 13,1916 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show Yes 2 No Director DC None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. ò or items 23a 4700 Central Avenue NE Funeral 20019 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status "natural", or item Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2√2 No Specify þ Specify: Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the 12 Federal Protective Service Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 Is marked ott Be Grover L. Ford, Sr. Mimma Chambers Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 tment of Health Kenneth Ford / Son 11303 Sherrington Court; Largo, MD 20774 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 0 permit. Pages
Department o
Important; If any injury or
once. Ft. Lincoln Cemetery 01/10/08 4 ☐Donation 5 ☐ Other (Specify) Bladensburg, MD 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee 278 MD 3831 Georgia Ave, N.W. Wash., D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Pneumonia 2 Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Liseaus or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ <u>Advanced Dementia</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed^a certificate 2 No 1 ☐ Yes 2 ☐ No Physician; funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 🔯 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 🖂 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day Year) 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident 24 hours after death e Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37934 01/09/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Center Drive Suite 430 Stephanie Trifoglio, M.D. Greenbelt, MD 20770

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN

10

2008

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

egistrar's Signature

■ Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Registrar		State of IVI	arylano		tificate of I		•	gierie Reg. No.	2002	01031
		Decedent's Name (Firs	t, Middle, Last)		_				2. Date of De Month	ath Day	Year	3. Time of Death
Physicia /Medic		Roberta	Frison						Januar	-	2008	2:33 A M
Examin	-	4a. Facility Name (If not in	nstitution, give s	treet and number)			4b. City, Town, or	Location of Death		4c. C	ounty of Death	
	ğ	Prince Geo			an the same to	- 4 t- :- 4tt \	Cheve	r 1y If Under 24 Hrs.	Data of Die			eorge's
Funeral Director		5. Social Security Number	1 🗆	M 217 F	ge (In yrs. la	St Dirthday). Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da	y, Year)	Cour	**
*	-	578-50-619 Usual Residence of Dece							March 6	, 193	0   Sout	h Carolina
ylanc how at		10a. State 10b.	County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
e Mar	ctor	Maryland P	rince G	eorge's	Te	emple	Hills					fX Yes 2 □ No
or 28	Director	10e. Street and Number				1	10f. Zip Code			10g. Citize	n of What Cour	ntry?
ath w		2405 Sout						748			ed Stat	
er de	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	>	. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	-   14	Black, White,	
urs a al', o	ρ	1 Never Married 2 3 Widowed 4 D		1  Yes 2  X If Yes, Give Year or Dates:	INO		1 □ Yes 21 No	Specify:		s	pecify: B	lack
72 hc 'natu dical	Completed	15. D (Specify onl	ecedent's Educ	eation completed)		(Give	dent's Usual Occup	during most of worl	king	16b. Kind	of Business/Inc	dustry
ne. han "		Elementary/Secondary (0-12) College (1-4or 5+)										
lled w tygie her ti nt, th		12 years 17. Father's Name (First,	Middle Lasti			Foo	d Service	Norker  18. Mother's Name	n (First Middle		vernmen	t
ntal Hed ot	Be		,							ivialueri Si	urname)	
hould id Me mark matic	<u>٩</u>	George Da  19a. Informant's Name/R		ne Print)		19b Mailin	g Address (Street	Ann Cro		er City or i	Town State Zin	Code)
nd 2 s Ith an 27 Is		W.V. Frison					Southern					
f Hea f Hea item 3		20a. Method of Disposition	n		20b. Pla	ace of Dispo	sition (Name of matory or other place	i	Date		ation - City or To	
Pages 1 nent of Ho nt: If Iter iry or oth	П	1 TyBurial 2 □Crei 4 □Donation 5 □ 0		emoval from State		· ·	Cemetery	i i	17, 200	8 Wa	shingto	n. DC
permit. Departm Importal any Inju	ı	21. Signature of Funeral	_		1		. Name and Addre					
Dermi Depa Impo any I		MOUN	1.19	Duca	V-++	4	001 Benni	ing Road,	NE Was	hingt		
₩		23a. Part1. Enter the disc shock, cheart failu	ease, or compli ire. List only or	cations that cause e cause on each li	d the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a		Acu	te h		a continued	troke			Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):	- 0	76				,
	_	Sequentially list condition	is, b	Due to (or as	2,6	100 of	e sno					days
ted nsit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury		Duc to (61 as	570	1 12 0	ceccer	1 has	traem	< B		days
execunand nand ial-tra	Exal	that initiated events resulting in death) Last	С	Due to (or as	a conseque		,	1 Care				3-3
tificate be executed g physician and as the burial-transit	edical		d	me	tasto	elic	meai	1 Care	inoma			Weeks
ntifica ng ph as th	≪ !	IF FEMALE.										
tth ce tendir	sician/	IF FEMALE: 23b. Was decedent pregr	iani	3c. If yes, outcome 1 ☐Live birth			Ectopic pregnancy	,		23	d. Date of delive	-
or Attending Physiclan: The law requires that the death cer death.  Director: After this certificate has been signed by the attendir  by the funeral director, page 2 should be detached for use	sici	in the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	15 ?	4□Pregnant a 9□Unknown	t time of dea	ath 5□	Other (specify)				Month	Day Year
hat the	Phy	Part II. Other significant	conditions con	tributing to death b	out not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use	e contribute to the	he cause of death?
signe d be o	Completed by	Consesta	,	4 4			aertie			Yes 2□		
v requestions	etec	2. 1 50	A .	e gens ta	A	C m		aeule	24a. Was		Odb Ware outs	unau findinga quailabla
ne lav e has ge 2 :	d L	me best	toave 1	$\Theta_{i}$	4	- 101	al til	aceux	autoj		prior to co death?	psy findings available mpletion of cause of
in: Ti ificate or, pa	္မွိ -	25. Was case referred to	madical madical	arker	neu	o ocu	u Janu	OF Place of Page	1  Yes	2 No	1 🗆 Yes	200No
/sicla	മ	examiner?		ospital:	ent 2∏E	R/Outpatien	t 3 DOA Oth	26. Place of Dea	ome 5 ☐ Resi		Other (Specif	5/1
g Ph)	٦. T	27. Manner of Death		28a. Date of Inju	iry 2	28b. Time of		y at	28d. Describe			y/
ath. rr: Aft	atio	1 X Natural 5 □ 2 □ Accident	Pending investigation	(Month, Da	iy rear)	Injury		Yes 2 □ No				
er de	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined		ury - At hom tc. (Specify)		eet, factory, office		28f. Location (3		Number or Rura	al Route Number,
urs at												
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled — by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Construction (Check only one)	Certifying Phys Medical Examir	ician: To the best ner: On the basis of and manner st	of examination	ledge, death on and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) a date and p	nd manner as s place, and due to	tated. o the cause(s)
To th within To th	Me	29b. Signature and title of	f certifier	Dui	taxi	mo	29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
5		30. Name and address of	person who co	mpleted cause of o	death (Item 2	23a) (Type,	29c. Licens D3 Print) RA CHENER	VINDER	R. R	ust	AQI M	Ø
		6132		LOOVER	Ros	0,0	HENER	y m	0 20	785		
Stat	-	31. Date filed (Month, Day	4 2008	2. Registr	rar's Signatu	ire does	W					
Registra	ar	JAN I	4 2000	Plane	, ,,,,	7						

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

701

32. Registrar's Signature

Par L W. Morte

JAN 1

31. Date filed (Month, Day, Year)

Physician

/Medical

Examiner

Director

Completed by Funeral

To Be

Be Completed by Physician/Medical Examiner

Certification: To

Medical

use as the burial-transit

	pe or Print in B						_	ible.	
1 - State Registrar	State of Marylan		tment of i		d Mer		ene . №.?	08	01935
Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
WALTER FLORENCE, JR  4a. Facility Name (If not institution, give str.			4b. City, Town, o	or Location of D		nuary	4c. Count	2008	12:40 PM
Civista Medica	al cente	r	La La	Plat	7	'	C	ark	25
5. Social Security Number 6. Sex	7. Age (In yrs. I	- 11	If Under 1 Year Months Days	If Under 24 I		Date of Birth (Month, Day, Y	ear)	9. Birthpla Countr	ace (State or Foreign
Usual Residence of Decedent	74 74	Yrs.	Dayo	710010	$\propto$	TOBER 3,	1933	GEORG	ŠIA
10a. State 10b. County	10c. City	, Town or Loca	ition		-			100	d. Inside City Limits
MARYLAND CHARLES	1	POMFRET							1 ∏Yes 2 □ No
10e. Street and Number	,		10f. Zip Code			10g	. Citizen of	What Country	y?
8030 MARSHALL CORNE			206	-				STATE	
11. Marital Status 12. 1 □ Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 12 Yes 2 No 19 If Yes, Give	55- If Y	as Decedent of F es, specify Cub	Hispanic Origin? an, Mexican, Pi Specify:	? (Specify uerto Rica	Yes or No- an, etc.)	Bla	ce - Americar ck, White, et	
3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 19	J1	Yes 2√X No				Specif	DLA	
15. Decedent's Educat (Specify only highest grade c	ompleted)	(Give kir	nt's Usual Occup nd of work done O NOT use retire	during most of	working	16	b. Kind of B	usiness/Indu	istry
Elementary/Secondary (0-12)	College (1-4or 5+) YEAR		HANDLER	u)		F	EDERAI	L GOVE	RNMENT
17. Father's Name (First, Middle, Last)				18. Mother's I	Name (Fi	rst, Middle, Ma			
WALTER FLORENCE, SR	•			JESSIE	В. 1	IENDLEY	FLOR	ENCE	
19a. Informant's Name/Relationship (Type.			Address (Street						Code)
THELMA FLORENCE / W. 20a. Method of Disposition	LFE 20h PI	P.O. Be	OX 85,	POMFRET	, MAI		2067.		- Olate
1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	noval from State	emetery, crema	tory or other pla	· ·				-City or Tow AM, MARY	
21. Signature of Funeral Service Dicense	John MODERS	THO	ORNTON	FUNERAL	HOMI	E, P.A.	N TITLAT	D. MAD	WI AND 200/10
23a. Part1. Enter the disease, or complicate	NSON MO0583							<i>A</i>	YLAND 20640 Approximate
shock, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	Cardiac	tern	porque	de				6	nterval Between Onset and Death
	Due to (or as a consequ	ence of):		ligen	-				Leun
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ende off.	my o	esters	ب				0
cause. Enter Underlying Cause (Disease or injury that initiated events	diale-	tes	V						years.
resulting in death) Last	Due to (or as a consequ	ence of):	_						0
d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3⊟Eo	ctopic pregnancy	/				te of delivery	ay Year
Part II. Other significant conditions contrib	outing to death but not resul	ting in the unde	erlying cause giv	en in Part I.			co use cont 2 ☐ No	iribute to the 3  Probat	cause of death?
tinemia						24a. Was an autopsy performed		Were autops prior to comp death?	sy findings available oletion of cause of
25. Was case referred to medical				26. Place of I			No	1 ☐ Yes 2	□No
examiner? 1 Yes 2 No Hos	pital: 1 ☑ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Oth	or:		5 ☐ Residence	e 6 🗍 Oth	er (Specify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1		_	Describe how i			
a Could not be	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, street,		2 140	28f. I	ocation (Stree City or Town, S	t and Numb tate)	er or Rural F	Route Number,
29a. Certifier (Check only one) (Check only one)	an: To the best of my know : On the basis of examination	ledge, death or on and/or inves	ccurred at the tir	ne, date and pla pinion, death o	ace, and o	due to the caus	e(s) and ma	anner as state	ed. he cause(s)
29b. Signature and title of certifier	and marrier states.		29c. Licens	e number		29d	Date signer	d (Month Da	v Year)

within 24 hours after death.

To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should

State

Registrar

E. Chules

20646

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:09 P. M 20, 2008 January Lorraine Darlene Geiser /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 24426 Graham Ave. Smithsburg Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M XX F March 4,1933 Pennsýlvania 74 218-30-8917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Smithsburg Md. Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 24426 Graham Ave. 21783 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lee C. Davis Ethel M. Downin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24426 Graham Ave. Smithsburg, Md. 21783 Robert C. Geiser (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 24, Smithsburg Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Smithsburg, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 Approximate Interval Between Priset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final month disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes

**Physician** /Medical **Examiner** 

law requires that the death certificate be executed

peen

Jas

After t al or Attending F

neral Director: / filled in by the f

To the Hospital of within 24 hours at To the Funeral D

Box 68760,

Division or Vital Records, P.O.

**Funeral** 

Director

show

ral", or items 23a or 28a-f shov Examiner must be notifled at

"natural",

traumatic event, the Medical

is marked other than

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traum

2 should be 1 and Mental

Baltimore, Maryland 21215-0036

Examiner physician and s the burial-transit Physician/Medical attending p signed by the a ģ Completed funeral director Be Certification: To

1 ☑ Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check onl) one)

24a. Was an autopsy performed

1☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death Check onl o Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

28h. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature

25. Was case referred to medical examiner?

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

State Registrar

Medical

31. Date filed (Month, Day, Year)

25

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Marylan		artment rtificate			ınd Me		jiene leg. No.	008	01937
9	Physici		1. Decedent's Name (First, Middle, La	M. Greene						1	Date of Dea Month	th Day	08 Year	3. Time of Death 12:50 P. M
	/Medio	_	4a. Facility Name (If not institution, gir Greater Laurel Healt	ve street and numb		Center	4b. City, 1	own, or Lau	Location o			4c. 0	County of Dea	
	Funeral Director	**	Social Security Number 6.		Age (In yrs. I		If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birth Month, Day			rthplace (State or Foreign ountry) Slyn, VIrginia
	T)	٥٢	Usual Residence of Decedent  10a. State 10b. County		10c. City	r, Town or Lo		Lot ch	to					10d. Inside City Limits 1 X Yes 2 □ No
	vith the N or 28a-f	Director	Maryland Prince G			LE CE	10f. Zip		20743			-	en of What C	ountry?
336	uges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene.  If Item 27 is marked other than "naturel", or Items 23e or 28e-f show or other freumatic event, the Medical Esanian must be notified at	by Funeral	1300 Nye Street  11. Marital Status  1XXVever Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	as? ⊠ No		Was Decedent Yes, special				ify Yes or No- ican, etc.)	1		
ltimore, Maryland 21215-0036	d within 72 hou giene. er then "nature. . It e Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		or 5+)	Registered Nurse					16b. Kind of Business/Industry Prince George's Hospita Center		ge's Hospital	
and	ld be file ental Hy ked oth	To Be (	17. Father's Name (First, Middle, Las Walter Ja	mes Greene					18. Mothe		First, Middle, ergaret V			.ey
Mary	id 2 shou Ith and M 27 is mar treumat	-	19a. Informant's Name/Relationship Margaret C. Greene (		-	19b. Mailir 8519 (	ng Address Greenbe	(Street a. 1t Ro	nd Numbe ad #10	or or Rural Y4 Gree	Route Numbe	r, City or Maryla	Town, State, and 207	Zip Code) 70
more,	permit. Peges 1 and 2 Department of Heelth a Important: If Item 27 is eny Injury or other tree		20a. Method of Disposition  1  Burial 2  Cremation 3 ( 4  Donation 5 Other (Speci		Cé	lace of Dispo emetery, crer sapeake	matory or ot	her place	) Ja Inc.	anuary	^t 9, 2008			r Town, State Maryland
Balti	permit. Departm Imports eny Inju		21. Signature of Funeral Service Lice	nsee /		<b>'</b>	2. Name and			NOL	lins Fun shington			
100	Physician /Medical Examiner prize pe provided /Medical (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (taus) / (t	dicai Examiner	23a. bart. Enter the disease, or conclude, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Laryne Due to (or b. Due to (or	eal. Canc as a consequ as a consequ as a consequ as a consequ	Denot ent  Der  Jence of):								Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific Ne has been signed by the attending p age 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√√No 9 □ Unknown		n 2 ☐ Fetal tat time of de	death 3	Ectopic pre Other (spe					2:	3d. Date of de Month	elivery Day Year
ds, P.	uires that t signed by Id be detac	by	Part II. Other significant conditions	contributing to deat	h but not resu	atting in the u	nderlying ca	iuse give	n in Part I.			bacco us		to the cause of death?  Probably 4 Unknown
Division of Vital Records,		Completed									24a. Was autop perfor 1 Yes	sy	death?	utopsy findings available completion of cause of s 2 No
Vita	nysicien: Th nis certificete director, paç	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ➡ No	Hospital: 1 ☐ Inp	atient 2□	ER/Outpatier	nt 3 DO.	A Othe	-		(Check only one of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of t		☐Other (Sp.	ecify)
25. Was case referred to medical examiner?  1										3d. Describe h	ow injury	occurred		
Divis		Certification:	3 Suicide 6 Could not determined	200. Flace of	Injury - At ho , etc. (Specify	me, farm, str	eet, factory,	office		28	Bf. Location (S City or Tow	treet and n, State)	i Number or F	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	edical (		hysicien: To the besi miner: On the basi and manner	s of examinat									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	show &	- m	D		License MD534			J	29d. Date	y 8, 200	nth, Day, Year)
2	,		30. Name and address of person who Jagdish Shesadri, M.		of death (Item Callant )	23a) (Type, Fox Lane	Print) e Suite	#210	) Bowie	e, Mary	yland 2	0715		
75%	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 1 2008	32. Reg	istrar's Sign	ture								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** January 5, Catherine Delaphine Gore 2008 10:56a.[™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/02/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🙀 F 577 36 7737 86 Director Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Prince Georges Hyattsville 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 5821 Queens Chapel Road, #159 20782 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0. Specify: African Amer. 1 ☐ Yes 2 ☐ No þ 3 t Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 Is marked other this any Injury or other traumatic event, the once. Dept. of Commerce Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Shirley Lottie Yates မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11919 Elmwood Dr., Brandywine, MD 20613 John I Shirley, Jr.-Nephew 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₱∐Burial 2 ☐Cremation 3 ☐Removal from State Mt. Olivet Cemetery 01/11/2008 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21. Signature Funeral Service Licensee Washington, DC 3015 12th St., NE Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) this c Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 1 ☐ Yes P 2 ER/Outpatient 3 DOA 27. Manner of De 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46998 Hamilton ST#1 Hyallsville Mnzo782 10 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAXMI BERWA M.D.

31. Date filed (Month, Day, You 1 1 4 2000

**JAN 14** 

D24535

7700 OLD BRANCH AVENUE CLINTON, MARYLAND

**JANUARY** 

20735

10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland	-	artmen rtificat			and M		Reg. No	/ 111118	01940
п	Physici	an	Decedent's Name (First, Middle	Last)							<ol><li>Date of D Month</li></ol>	eath Da	ıy Year	3. Time of Death
	/Medi		Martha	Ginsburgh			Y				Jan 6			1:45pm M
4	Examir	ier	4a. Facility Name (If not institution,	•			4b. City,	Town, or	Location o	f Death		40	c. County of De	ath
	,		Potomac Valley						lle, N				Montgom	
	Funeral			6. Sex 7. 1 □ M 2 XF	Age (In yrs. la 82	ast birthday) Yrs.	If Under Months	1 Year Days	If Under :	Min.	8. Date of B (Month, D	irth ay, Year,		irthplace (State or Foreigr Country)
·	Director		Usual Residence of Decedent			115.					09/30	/192	5 Ne	w York
	land wo		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	Mary feb	ō	Virginia Fairfa	x	McLe	ean								Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. It is naturel, or iteme 23a or 28a-1 ehow event, the Medical Examinar must be notified.	Funeral Director	10e. Street and Number 1110 Wimbleton				10f. Zip		-				itizen of What C	
	eath	era	11. Marital Status	12. Was Decede	ent Ever in U.S	S.   13			snanic Orio	nin? (Spe	cify Yes or N	0-	14. Race - Am	perican Indian
	fler d	Fun	1 Never Married 2 Marrie	Armed Force	es?		If Yes, spec	ofy Cuba	n, Mexican	, Puerto F	Rican, etc.)		Black, Wh	nite, etc.
93	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes	2K No	Specify:				Specify: Wh	ite
21215-0036	2 hou	Completed by	15. Decedent			16a. Dece	dent's Usua	al Occupa	ation			16b. k	Kind of Busines	s/Industry
215	C 58	pie	(Specify only highest Elementary/Secondary (0-12)	T	0(54)	(Give life.	kind of wo DO NOT us	rk done d se retired,	lurin <b>g</b> most )	of workin	g			
21	filed within Hygiene. Sther then sent, the Men	mo:	Elomoniary, Sociality (6 12)	College (1-4		Clerk						U.S	G. Gove	rnment
pu	al Hygie I other vent, II	Be	17. Father's Name (First, Middle, L								(First, Middl		n Sumame)	
<u> a</u>	should be I and Mental I marked of urnatic eve	2	A. Robert Gins	burgh					Elsi	ie B.	Pinne	ЭУ		
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the M	ľ.	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rural	Route Num.	ber, City	or Town, State,	Zip Code)
	127 E		Anne Wolfe / S	ister					Dr.	McLe	an, V	221	L01	
ore.	0 0		20a. Method of Disposition 1 □XBurial 2 □ Cremation	2 Demousi from St.	1 00	ace of Dispo	sition (Nan	ne of ther place	9) ! 1	1/17/	2008	20c. L	ocation - City o	r Town, State
Ĕ	Pages nent of ant: If it ury or o		4 □Donation 5 □ Other (Sp			e of H	eaven	Сет	ot !				er Spr	
Baltimore,	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service L	icensee	05(7)	22	. Name an	d Addres	s of Facility				s Sons gton, D	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cau	sed the death.	. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	inly one cause on eac		4	1.	+1	J. 1. /					Onset and Death
18	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	ence of):	10	1 7 1	TIV	<u>C</u>				
	Examiner			Av	-) 1)	(rd		en	ent	G				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	ence of):			- 10-					-
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oʻ	en ar	EX	resulting in death) Last	Due to (or	as a consequ	ence of):			,					
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9	tifica ng ph as th	led		I					· · · · · · · · · · · · · · · · · · ·					
Вох	eath certific ettending p for use as 1	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pr						23d. Date of de	elivery
	death e ette	icia	in the past 12 months? 1 □ Yes 2 🖫 No	4□Pregnan	it at time of de		Other (sp						Month	Day Year
P.0	at the de by the	hys	9 Unknown	9□ Unknow	n 									
	The law requires thet the death certific, ite has been signed by the ettending plange 2 should be detached for use as to	by P	Part II. Other significant condition	ns contributing to deat	th but not resul	lting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco	use contribute	to the cause of death?
ğ	w require been sig should t	edi									1 🗆	Yes 2	. <b>X</b> No 3□F	Probably 4 Unknown
သို့	law requast been 2 should	Completed									24a. Wa		24b. Were a	autopsy findings available
æ	The lay	E									per	opsy ormed?	death?	
Vital Records,		a	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only		1016	5 2 2 140
$\geq$	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inp	atient 2 🗆 E	R/Outpatien	t 3 DO	A Othe	_				6 □Other (Sp	ecify)
J of			27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time of Injury	2	8c. Injury Work			8d. Describe			
Ö	Attending r death. •ctor: After	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		buy rour,	пцату	м		res 2 □ N	No				
Division	Pr de	tific	3 ☐ Suicide 6 ☐ Could not determine determine	and 280. Place of	Injury - At hor, etc. (Specify)	me, farm, str	eet, factory	, office		2	8f. Location City or To			Rural Route Number,
ō	tal or s afte al Dir	Certification:		building	, 510. (Spacify)						Ony of 10	www. Jidi	<b>υ</b> ,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basi and manner	is of examination	vledge, death on and/or in	occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the d at the time	cause(s , date an	and manner a d place, and du	as stated. ue to the cause(s)
	Fo the Mithin Fo the Somple	Me	29b. Signature and title of certifier	-/				. License					ate signed (Mor	
	> - 0		1 377	(M	$\sim$	01	9	00	600	4 ?	5	1	171	2008
•	13		30. Name and address of person w	no completed cause	of death (Item	23a) (Type	Print)	1	00	\ \ \ \ \ \ \ \		( /	( /	
	V-		SAYED EI	SAYYAN	9710	- 11	11/9	1/2	ente	10	· ?	ock	ville.	2008 MI) 20850
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signatu		~~		- V		12	•		-
SE	Registr		.IAN 1 0	2008	A. A	Car	BAR P							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Jean I. Gean 2008 January 10:22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 👿 F 104-12-1888 85 Nov. 1, 1922 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No MD Calvert Chesapeake Beach 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8545 St. Andrews Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jay Ireland Helen Bartlett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Gean - grandson 3209 Prince Henry Ct. Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/9/2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, Maryland 20852 23a. Part1. Env: the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failvre. List only one cause on each line.

Immediate Cuure (Final disease or condition resulting in death)

a. Cerebral Vascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23d. Date of delivery Month Year Day le. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ No 3 🗆 D 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 ☐ Pending investigation 1 X Natural 2 Accident

Physician /Medical **Examiner** Examine The law requires that the death certificate be executed and attending physician Physician/Medical Completed by

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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**Funeral** 

Director

After this 24 hours after death e Funeral Director:

Be

Certification: To

Medical

or Vital Records,

Division

To the Hospital or Attending Physician:

within 2

1 Sets of death 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	
ns contributing to death but not resulting in	the underlying cause given in Part I.	23
		24
		10
	1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)

Place of injury - At home, farm, street, factor building, etc. (Specify)

			perfo	ormed? 2 <b>X</b> No	death?	2 □ No
	26.	Place of Death	(Check only	ne)		
OA (	Other: 4	☐ Nursing Ho	me 5□Resi	dence 6	SXIOther (Specil	y)Hospice
-	njury at Vork? □ Yes	2 🗆 No	28d. Describe	how injury	y occurred	
y, offi	ce		28f. Location ( City or To	Street and wn, State)	d Number or Rura	al Route Number,

29a.	Certifie	91
	(Check	on
	one)	1

3 ☐ Suicide

4 Homicide

31. Date filed (Month, Day, Year)

1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Signature and title of certifier	/ /	1.0	6	^
Overene	M	se con	X	m

29c. License number D0064615

29d. Date signed (Month, Day, Year)

January 8, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive Rockville, Maryland 20850 Genevieve Anne Wroblewski

State Registrar

JAN 1 0 2008

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:45 AMM **Physician** Jamuary 23°, 2008° Maryland Lloyd Hale /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, )ec. 6, 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 **T**M 2 □ F 87 Maryland 727-09-6498 Dec. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f sho 1 □Yes 2 No Jefferson Frederick Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be U.S.A. 21755 2751 Lander Road death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2XXVo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes XX No White Specify: Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mable Merchant Silas Hale ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) P.O. Box 212, 2931 Fry Road, Jefferson, MD 21755 John Hale, nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Methodist Cemetery Jan. 26, 2008 Jefferson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THRIVE Physician FAILURE TO /Medical Due to (or as a consequence of): **Examiner** CARDIO MYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of r. Examin burial-trans Due to (or as a consequence of): Physician/Medical the attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s death? 1 ☐ Yes 2 DNo 2 1 No 1☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A

Baltimore, Maryland 21215-0036

Medical

31. Date filed (Month, Day, Year) State JAN 2 Registra

29b. Signature and title of certifier

29a. Certifier (Check only one)

> A KAZMI, MD 32. Registrar's Signatute

and manner stated.

THO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

814 TOW HOUSE AVE FREDERICK

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

08-00258

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Barbara V. Hagans	1- F	or State	tate	of Maryla	and / De	part Certi	ment of ficate of	Health Death	n and	Menta	ıl Hyg		g. No.	2(	008	)   9
Dhusisian/	Doc	istrar Decedent's Name (First, Mid	dle,Last	)		-						Date of Deat	h Day	Year	3. Time of Deat	h
Physician/ Media 'Examiner	Е	ARBARA V. HA	GANS					4b. City, To	wn orl	ocation of		January 9	, 200	08 c. County of Deat	1000 hrs	
1	4a	Facility Name (if not institute Prince George's Hos			umber)		'	Cheve		ocation or				Prince Georg		
Funeral	5.	Social Security Number	6. Se		7. Age (in y	rs. las	t birthday)	If Under		If Under Hours	24Hrs. I	8. Date of Bir 09/09		M/DD/YYYY) 9. Bi	rthplace (State or gn NORTH ountry) CARO	
Director	2	43-64-3127	1	м 2 _X F	69	)	Yrs		Laye			09/09	/ 1 9	36	OUTITY) CARO	LINA
any	_	ual Residence of Decedent a, State 10b. Count	ty		10c.	City, T	own or Locat	ion							10d. Inside Cit	
≱			CE G	EORGES		CAP]	TOL H	EIGHT	S						1 X Yes 2	No
to 28a-f shuifed at once	10	e. Street and Number						10f. Zip	Code				Ü	itizen of What Co	untry?	
rdeath with the Maryland or items 23a or 28a-f show must be notified at once.		519 CEDARLEAD	F AV		ecedent Ever	in II C	13 W	207	43	anic Origi	n? (Spec	cify Yes or No		SA 14. Race - Ame	erican Indian, Bla	ck,
leath with	11	. Marital Status  Never Married 2	Married	Armed	Forces?		if \	es, specif	y Cuban,	Mexican,	Puerto R	ican, etc.)		White, etc.		
fer der ", or i	3	A		1 Yes or Dates:	ear	No 	1	Yes 2					lach	Specify: BLA		
iours afte		15. Decedent's Education (S		nly highest gr		ed)	16a. Decede during r	nt's Usual nost of wor	Occupati king life.	on (Give k DO NOT t	ind of wo use retire	rk done d)	160	), Kind of business	5/moustry	
within 72 hour giene. her than "natu Medical Exan		Elementary/Secondary (0-1	(2)	College	(1-4 or 5+)		CASI	HIER						PRIVATE	<u> </u>	
215-0036 be filed within 7 mal Hygiene. rked other than ent, the Medica	1	12TH 7. Father's Name (First, Mid	dle, Last	)					1	8.Mother's	s Name (	First, Middle,	Maide	en Surname)		
1218 I be file ental H arked vent, t	ו מ	WILLIE KINSES	<u> </u>	Type Brot )			19b Mailir	na Address	Stree	BESSI t and Num	E RC	WF. Iral Route No	ımber,	, City or Town, Sta	ate, Zip Code)	
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens in Mental Hygiens I is marked other than "natural", or items 23a or 28a-f sho important: If item 71 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Completed by Funeral Director	-	ga. Informant's Name/Relati CHARLES HAGAN			NT.		5003	VANE	COU:	RT WA	LDOR	F, MD	20	602		
e, M 1 and 2 1 and 2 Health item 2	2	0a. Method of Disposition    X   Burial   2   Crema		<b>,</b>			Place of Dispo rematory or o			netery,		Date	20	c. Location - City		ļ
MOF Pages ient of mut: If		Donation 5 Othe	Specify	y:	Tioni State	Re	surrec	tion	Cem.			18/08		Clintor		
Baltimore, ocmit. Pages 1 a Department of He Important: If ite	2	1 Signature of Funeral Service	rice Lice	nsee	1									FUNERAL , MD 207		
Physician	1 2	3a. Part I. Enter the disease	e, or com	plications tha	t caused the	death.	Do not enter	the mode	of dying,	such as c	ardiac or	respiratory a	arrest,	shock, or heart	Between C	nset and
€ edical		failure. List only one ca mmediate Cause (Final dise	use on e	each line. a. Multiple I											Dea	ath
aminer		or condition resulting in deat	h)	Due to (or a	s a conseque	ence o	f):									
		Sequentially list conditions, fany, leading to immediate		Due to (or a	s a consequ	ence o	f):									
	Ę١	cause. Enter Underlying Ca (Disease or injury that initiat events resulting in death) L	ed `	Due to (or a	as a conseque	ence o	f):									
executed an and al - transit		events resulting in death) L	asi (	d												
be exectician a lician a	dical	UNPENDED		AMENDE									_	23d, Date of deli	verv	
Box 68760 e death certificate I the attending phys	sician/Me	F FEMALE: 3b. Was decedent pregnant	in the		es, outcome i ve birth	of preg		Fetal deat	h 3	Ectop	ic pregna	incy		Month	Day	Year
ox 68 tth cert attendir ruse a	sicia	past 12 months?  1  Yes 2 ✓ No 9	Unknov	¬	egnant at tim nknown	e of de	eath 5	Other (Sp	ecify)							
the de <b>a</b>	≥1	Part II. Other significant co		90		ut not	resulting in th	e underlyi	ng cause	given in P	Part I.			acco use contribut		
of Vital Records, P.O. ng Physician: The law requires that the Milter this certificate has been signed by preneral director, page 2 should be detected.	g P											1		2 No 3	e autopsy finding	
v requir	lete											au	utopsy erforme	prior dear	r to completion of th?	cause of
Recc The lav	Completed								00 51-	ce of Deatl	h (Chack		es 2	No 1	Yes 2	No
cian: certifi	8	25. Was case referred to m examiner?	edical	Hospital:	Innatient	2 🗸	ER/Outpat	ent 3	DOA	Other 4		ng Home 5	Re	esidence 6	Other:	
of Vital Fing Physician: After this certifi	암	1 Yes 2 No 27. Manner of Death		28a. [	Date of Injury		28b. Time	of Injury		jury at Wo		28d, Descr Subject of	ibe ho	w injury occurred r of vehicle in	motor vehicl	e
ion (tending eath for: A)	Certification:	1 Natural 5 2 ✓ Accident	Pending	٩	Aonth Day, Yea 9, 2008		0930 hrs			Yes 2		accident		reet and Number		
Division tal or Attendin rs after death al Director: A	tific	3 Suicide 6	Could r	not be 28e.	Place of Inju		home, farm, s	street, facto	ory, office	building,	etc.	or Tov 202 Techr	vn, Sta nology	ate) y Way, , MD	0, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	,
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide 29a. Certifier 1 Certify					1 - 1 1	ccurred at	the time,	date and	place, an	d due to the	cause	(s) and manner as	s stated.	
To the Hos within 24 h	Medical	(Check only one) 2 Medica	it Exami	ner: On the ba	asis of exami ner stated.	nation	and/or inves	tigation, in	my opini	on, death	occurred	at the time, o	Jale al	nd place, and due		ar)
F 3 F 8	ğ	29b. Signature and title of	certifier	71	,					nse numbe C.M.E.	0	CME		January 10,		. /
(6)		T. K. sollen	W	the complete	Sylva of da	ath /lte	m 232									
(0,0)		30. Name and address of p Theodore M. King			sistant Me	edical	Examine	r 111	Penn S	Street, E	Baltimo	re, MD 21	201			
St	ate	31. Date filed (Month, Day			2. Registrar's	s Signa	ature									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** C. Rene Holloway 2:30 A /Medical January 9. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs. Director 577-26-6810 86 Sept 5, 1921 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 TYYes 2 □ No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Kensington Place, NE 20011 Funeral United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married r than "natural", or the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No þ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) l year Data Operator Government is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I Oliver W. Jackson ည May Griffin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is a Gregory C. Holloway - Son 3609 Scruggs Place Springdale, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) \( \) Lincoln Memorial Park Jan 13, 2008 Suitland, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cancer Physician Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pancreatic Cancer Months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dan to for as a consequence of certificate be executed burial-transil Exami and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the nse 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐Live birth 3 ☐ Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🖾No detached the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ☑Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ည 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the h and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 January 9, 2008

DHMH 17 Rev 1/2001

State

Registrar

Suresh K. Gupta, M.D. 9801 Georgia Ave #220 Silver Spring 20902

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

**JAN 1 4** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month RICHARD HILL, Jr Η. 1:20P M Jan. /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Laurel Health & Rehab Laurel
If Under 1 Year I If Under 24 Hrs. PRINCE GEORGES Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days **XX**M 2 □ F Hours Min 89 Director 217-18-2112 Sept.20,1918 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 27s. ---- any injury or other traumatic event. the Maryland Once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 √ Yes 2 No Director MD Montgomery Cloverly 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 315 Bryants Nursery Road 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2€No Specify: þ 41 - 45Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard H. Hill, Sr Carrie Williams 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20905 19a. Informant's Name/Relationship (Type. Print) Edythe E. Norton Hill (Wife) 315 Bryants Nursery Rd, Cloverly, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Riverdale Pk Crem 1/14/08 Riverdale, MD 4 □ Donation 5 □ Other (Specify) Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service L GIM Washington St Rockville, MD20850 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Alzheimers Sequentially list conditions, if any, leading to immediate cause. Enter Uncryit g Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I signed by the a 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s 1□ Yes 2X No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and tipe 29c. License number 29d. Date signed (Month, Day, Year) D0053235 1/7/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Darryl Hill, M.D.

1 0 2008

31. Date filed (Month, Day, Year)

2. Registrar's Signature

13625 Baltimore Avenue, Laurel, MD 20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $a^{\,\text{M}}$ Herlihy, January 8, Jr. 2008 7:06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14913 Waterway Drive Rockville. Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 192 Birthplace (State or Foreign Country)

New York 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday, **Funeral** Days Hours Months 1X M 2 □ F 120-22-8070 82 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show notified at Director 1 □Yes 2 TXNo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with Examiner must be Items 23a 14913 Waterway Drive 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or WWII 1 ☐ Yes 2€ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Contract Administrator T.B.M. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I-Important: If Item 27 Is marked old any injury or other traumatic ever once. Pages 1 and 2 should be a nent of Health and Mental John Jeremiah Herlihy Mary Helen Dinsmore ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick C. Herlihy/Son 14913 Waterway Drive, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 14, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Thehard L Hales 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending | IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specity) 4☐Pregnant at time of death ed by the a 9☐ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy 1□ Yes 2 X No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the

> State Registrar

31. Date filed (Month, Day, JAN 10

30. Name and address of per

Nakul Goyal,

MD

29b. Signature and title o



on who completed cause of death (Item 23a) (Type, Print)

3801 International Drive, #211, Silver Spring, MD 20906

29d. Date signed (Month, Day, Year) January 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Moira 9, рм Rita Higgins January 2008 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brighton Gardens-Columbia Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F Director 579-28-1228 1915 May 8, New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 TyYes 2 No Director Vermont Bennington Bennington with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 111 Grant Street 05201 USA · death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ∰ If Yes, Give Year or Dates: an "natural", or It 1 ☐ Never Married 2 ☐ Married 2**∤**□ No Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify þ Specify.White 3 ☐ Widowed 4 😾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Homemaker Own Home Pages 1 and 2 should be filed vent of Health and Mental Hygicant: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick Gannon Mary Ann Sherin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other tonce. 19 Angelica Drive, Framingham, MA 01701

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City Christopher K. Higgins/Son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3√☐ Removal from State 15, Jan. St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Hoesick Falls, NY 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Sign vure of Funeral Service Licenses 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Leukemia Immediate Cause (Final **Physician** 2 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Discussion of the initiated events. Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trag resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical the SS IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 1□Yes 2□No ed by the a detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death Check onl one Hospital: Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\times$  Other (Specify) Assisted 1 ☐ Yes 2X No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Living (Month, Day 5 ☐ Pending investigation 1 Natural after death. 1 Tyes 2 □ No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

within 24 hours a To the Funeral I To the Hospital

> State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person with

Harry Li, MD

and manner stated.

8600 Snowden River Pkwy., #301, Columbia, MD 21045 egistrar's Signature

completed cause of death (Item 23a) (Type, Print)

29c. License number

D56531

29d. Date signed (Month, Day, Year)

Jan. 10, 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Alexander Channing Hawkes 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 7, 2008 2017 hrs Hawkes Ashok Medical Examiner Alexander Channing 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign 215-73-8525 Months Days Hours Country) Maryland Director 2 1 X M 2 F July 28 2005 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No or 28a-f show Silver Spring the Maryland Mary land Montgomery 10g. Citizen of What Country? 10f. Zip Code 1 and 2 should be filed within 72 hours after death with the Mary!
Health and Mental Hygiene.
Fitem 27 is marked other than "natural", or items 23a or 28a-ler traumatic event, the Medical Examiner must be notified at a 10e. Street and Number USA 20904 11531 February Circle, Apt. 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Kever Married 2 Married 2X No Yes Specify: Black If Yes, Give Year Yes 2 X No specify: be filed within 72 hours after 4 Divorced 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) N/A None 21215-0036 0 18.Mother's Name (First, Middle, Maiden Surname) Alexandra Marie Hawkes 17. Father's Name (First, Middle, Last) Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11531 February Circle, Apt. 203, Silver Spring Baltimore, MD Wanda D. Hawkes/Grandmother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition rtment of E rtant: If it or other t crematory or other place) Burial 2 X Cremation 3 Removal from State Jan. 12, Pages 1 Metropolitan Crematory Alexandria, Virginia Donation 5 Other Specify 2008 permit.
Departm 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 2090 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Choking Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Aspiration of foreign object Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine eques. Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran /sician/Medical UNPENDED AMENDED #28acerME1/11/08,BMW,McCo Hospital or Attending Physician: The law requires that the death certificate be-14 hours after death. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ signed be deta 1 Yes 2 V No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available this certificate has been a il director, page 2 should 24a Was an prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ Hospital: examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 2 No 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Subject choked on foreign object Certification 1920 hrs 1 Natural 1 Yes 2 ✔ No Pending Jan 7, 2008 Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 1531 February Circle #203, Silver Spring, MD Suicide To the Hospital or within 24 hours at To the Funeral I determined (Specify) residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 8, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. 32. gistrar's Signatur State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month January19, 2008 Allen Lewis Heine, Sr. 415 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** X M 2 □ F Director 263-42-1454 Febuary16,1933 Florida Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Wauchula 1X Yes 2 □ No Director Hardee Florida 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 902 South 7th Avenue 33873 S.A.
14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces.

1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1952 1 Never Married Married 1 ☐ Yes 2X No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 ls marked other than Elementary/Secondary (0-12) College (1-4or 5+) Public Utilities Boiler Operator ortant: if item 27 is marked other injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Heine Jeffie Parrish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene K. Heine/Wife 902 South 7th Avenue, Wauchula, Florida 33873 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) WauchulaCitvCemetery1/25/08 Wauchula,Florida 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 00 disease or condition resulting in death) /Medical Due to (or as a convequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death Day 5 Other (specify) 1 Ves 2 No 9 Unknown signed by t. d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Monatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00535 Jaruary peales 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Dav Hendershot Marvin F. /Medical 1350 January 19,2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital Cumberland or 1 Year I If Under 24 **Allegany** 5. Social Security Number 8. Date of Birth (Month, Day, Jan 10, 6 Sev 7. Age (In yrs. last birthday) If Linder 9. Birthplace (State or Foreign **Funeral** Months 1**√** M 2□ F Min. Davs Hours ďβA Director 220-34-1852 70 Usual Residence of Decedent r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or 3 805 D. Camden Avenue 21502 USA Funeral and 2 should be filed within 72 hours after death vealth and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1▲DYes 2☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 🏄 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Trade Com. Employee-laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Hendershot Ada (McCusker) Hendershot ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10313 John Fager Court Ellicott City MD 21042 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a Ken Hendershot son item 27 i other 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/2008 MD Cresaptown 4 ☐ Donation → 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary artery diease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Por 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Dea Certification; 28a. Date of Injury 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Fo the Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural death. 1 ☐ Yes 2 ☐ No e Funeral Director; / 2 □ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) within 24 and manner stated. the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 0

8

State Registrar

JAN 2 5 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D36766

January

2008

Please	Type or Print in Black			
For State Registrar		epartment of Health and Certificate of Death	Mental Hygiene	01951
Decedent's Name (First, Middle, La	st)		2. Date of Death	3. Time of Death
WILLIAM HARO	LD HURST		January lin 200	18 2:40 P M
4a. Facility Name (If not institution, giv	re street and number)	4b. City, Town, or Location of Dea		eath
VAMouslandHeap	th Care Sustem	PERRY POINT	CECIL	
5. Social Security Number 6. S 232-58-3998	Sex 7. Ag (In yrs. last birtho 1 1 1 2 1	Months Days Hours Mir		Birthplace (State or Foreign Country) VA
Usual Residence of Decedent				
10a. State 10b. County MARYLAND CHARLI	ES 10c. City, Town o	n Location  NEWBURG		10d. Inside City Limits 1 ☐ Yes 2 No
10e. Street and Number		10f. Zip Code	10g. Citizen of What	Country?
9831 SYLVAN TO	URN	20664	U.S.A.	
11. Marital Status	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	(Specify Yes or No- 14. Race - A erto Rican, etc.) Black, W	merican Indian, hite, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Pyes 2 No It Yes, Give USAF Year or Dates: 54-57	1 ☐ Yes 2 ☐ No Specify:	Specify:WI	HITE
15. Decedent's Ed (Specify only highest gra	ducation 16a. D	ecedent's Usual Occupation Give kind of work done during most of wife. DO NOT use retired)	16b. Kind of Busine	ss/Industry
Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	PERVISOR OF SOC.	SERS. D.C.GOV	г.
17. Father's Name (First, Middle, Last			ame (First, Middle, Maiden Surname)	
WILLIAM C.	HURST	ETHEL	BOWLES	
19a. Informant's Name/Relationship (MICHELLE HURST-		Mailing Address (Street and Number or F 331 SYLVAN TURN	Rural Route Number, City or Town, State  NEWBURG, MD • 20	
20a. Method of Disposition	20b. Place of D	isposition (Name of	Date 20c. Location - City	
1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State INITY M	IEM. GARDENS 1-21	1-08 WALDORF,	AD.
21. Signature of Funeral Service Lice	nsee M00479	22. Name and Address of Facility RAYMOND FUNERAL LA PLATA MD. 20		
23a. Part1. Enter the disease, or com	oplications that caused the death. Do not one cause in each line.		ac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final	Bronchiectas			Onset and Death
disease or condition resulting in death)	Due to (or as a consequence of)	512		Whown
Sequentially list conditions,	b			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)			
that initiated events resulting in death) Last	C	:		
•	d			
IF FEMALE:				
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month	delivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?
			1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Julynknown
			- autopsy prior	autopsy findings available to completion of cause of
			performed? death 1□ Yes 2 No 1 □ Y	?
25. Was case referred to medical examiner?	No. of the last		eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpa		Home 5 ☐ Residence 6 ☐ Other (S	pecify)
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim Inju		28d. Describe how injury occurred	
3 Suicide 6 Could not be determined			28f. Location (Street and Number or City or Town, State)	Rural Route Number,

/Medical **Examiner** Examiner attending physician for use as the buria Physician/Medical Be Completed by Medical Certification: To 1 - For State Registrar 1. Decedent's N

29a, Certifier

Director

Funeral

Be Completed by

ပ

Physician

/Medical

Examiner

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

death with the Maryland

within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

34

29c. License number

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

29b. Signature and title of certifier

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of F rtificate of			enę∠ U ( g. No.	10 0132
	Physic		Decedent's Name (First, Middle, THOMAS RAY	Last) HALL				2. Date of Death Month JANUARY	D .	3. Time of Death 7:39p
	/Medi Exami		4a. Facility Name (If not institution, Union Hospita	-		4b. City, Town, o	r Location of Death		4c. County	
34	Funeral Director		094-20-2194	5. Sex 1 2 M 2 □ F	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 5 1	926	9. Birthptace (State or Fore Country) Pennsylvani
	yland pow		Usuat Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limi
	e-fet	ctor	MD Ceci:	L	Earlev:	ille				1 ☐ Yes 2 <b>X</b> N
	vith the	Dire	10e. Street and Number	Laland Dd	Glen 8	10f. Zip Code	^	10	g. Citizen of W	•
	eath v	erai	645 Knights	12. Was Decedent		2191		cify Ves or No.	U.S.A	- American Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28e-f ehow many injury or other treumatic event, tre Medical Examinar must be notified at ADGE.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	No	If Yes, specify Cub 1 ☐ Yes 2 ☒ No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	Rican, etc.)		K, White, etc.
15-(	in 72 h n "netu Asolice	piete	15. Decedent' (Specify only highest	grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of working)	ng C	6b. Kind of Bu	siness/Industry Cial
212	d within giene.	mo	Elementary/Secondary (0-12)	College (1-4or	O+)		on Labore		onstr	uction
Maryland	tould be filed Mental Hygin Parked other	To Be (	17. Father's Name (First, Middle, L Richard Samue	•			18. Mother's Name Beulah			9)
	and 2 sho salth and n 27 is m er treum		19a thformant's Name/Relationshi	y (Type, Print) (Wife)		ng Address (Street Box 35	and Number or Rura GO Georg	getown,		State, Zip Code) 21930
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.	B □Removal from State	20b. Place of Disponsion Cemetery, cres Kent Cr	sition (Name of natory or other place emation	(e) 1/21		oc. Location - ( Smyrna	City or Town, State
Balt	permit. Departr imports eny inj		21. Sign lure of Funeral Service L	101/	M00510	Name and Addre alena F 18 West	ss of Facility uneral H Cross S	ome of	Steph ena, M	nen L Schae
·#			23a. Part: Enter the disease, or of shock, or hear faiture. List of	omplications that caused nly one cause on each li	the death. Do not ent	er the mode of dyir	g, such as cardiac o	respiratory arres	st,	Approximate Interval Between Onset and Death
*	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	-	AILURE 7	o THE	Œ			Oliset and Death
	Examiner			Due to (or as	a consequence of):	A 2 D	Emas 7cm	<b>a</b>		
^	P =	ner	Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	725	Citionio	,		
B.	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
68760,	tificate be executed g physicien and as the burial-transit	calE		d Dua to (or as	a consequence of).					
	rtificat ng phy as th	Medical	IC SEMALE.							
.O. Box	The law requires that the death cert tie has been signed by the attending rage 2 should be delached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery th Day Year
<u>α</u>	es that igned by be deta	by Ph	Part II. Dther significant condition	s contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part t.	23e. Did toba	acco use contri	bute to the cause of death?
ord	w require been sig should t							1 🗆 Yes	2 🗆 No	3 Probably 4 Unknow
Il Records,		Completed						24a. Was an autopsy perform	ed? pi	/ere autopsy findings availab rior to completion of cause of eath? □ Yes 2₽No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	ding After fune	tion: To	1 Yes 2 No  27. Manner of Death 1 Naturat 5 Pending 2 Accident investiga	28a Date of this (Month, Da	ry 28b. Time of	28c. Injun Wor	4   Nursing Hor	ne 5 Residen 8d. Describe how		
Division	of or Attending after death. Director: After in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Ann Blanca of this	ury - At home, farm, str c. (Specify)		_	8f. Location (Stre City or Town,	et and Numbe State)	r or Rural Route Number,
	To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	edicai C	29a. Certifier Certifyin (Check only 2 Medi 5	P ysician: To the best miner: O the basis of d manner sta	fexamination and/or inv	occurred at the tir restigation, in my o	ie, data and place, a pinion, death occurre	nd due to the cau d at the time, dat	sc(s) and man e and place, a	mer is stated. nd due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of perutie	1		29c. Licens		290	d. Date signed	(Month, Day, Year)
			· ///t	001~		054	073	12	21 JA	J 08
	2		30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type,	Print)	15 /24	NO	1/1125	08 0E 19720
Kg	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	estel	aus circ	- /451	Wishe	1111100
18 C	Registr	ar	JAN 25	سنون 2008	0 10 19	ar - gran				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Victoria Sharion Robinson Jones 2008 Jan. 6, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heartland Health Care Center Prince Georges Hyattsville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗙 F 579-62-1020 61 Washington, DC 10/26/1946

10d. Inside City Limits 1 ☑ Yes 2 ☐ No

Approximate Interval Between Onset and Death

U.S.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Black, White, etc.

10c. City, Town or Location

/Medical Examiner **Funeral** Director filed within 72 hours after death with the Maryland Hygiene. la or 28a-f show t be notified at ms 23a r than "natural", or items the Medical Examiner mu 3altimore, Maryland 21215-0036 h and Mental Hygier 7 is marked other th should be Pages 1 and 2 that the death certificate be executed physician and s the burial-trans Box 68760 attending p for use as as ed by the a detached f Division or Vital Records, P.O. signed b cate has I page 2 s certificate

**Physician** 

Usual Residence of Decedent

10h County

10a State

this

Director DC N/A Washington 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20017 1316 Galloway St., N.E. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black ğ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emanuel Robinson Thelma Morse 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other transonce. Thelma M. Robinson Mother 1316 Galloway St., N.E. Wash. D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crem. 1/14/08 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave., N.W. Washington, DC 12 21. Signature of Fune al Service Licensee Jhon. andre 7000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hypertension Completed 24a Was an Back Pain 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b hours after 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058290 January 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarvis Ave., Suite 200 Riverdale, MD 20737 M.D. 5711 Suresh K. Muttath, 31. Date filed (Month, Day, Year) State JAN 10 Registrar

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0008

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40		-	-	

				Certificate of Death	Reg. No.					
		1. Decedent's Name (First, Middle, L.	ast)		2. Dete of Deeth	3. Time of Deeth				
	Physician				Month / Dey Y	rear 45				
	/Medical	Jean Lind	oln Kapp			MA 1188				
	Examiner	4e Fecility Neme (If not institution, gi	ve street end number)	4b. City, Town, or L	ocation of Deeth 4c. County of	Deeth				
7	LAUTITIO	Brookfield Manor	. Doo!dont Cou-	Middleb	ura	Carroll				
			Sex 7. Age (In yrs. les	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s						
	Funeral		- MA -	Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year)	Birthplace (State or Foreign Country)				
	Director	067-18-2534	1 M 2KJF 87	115.	May 22, 1920 \	Vermont				
	D	Usuel Residence of Decedent								
	arylar show	10a. State 10b. County	10c. City, 7	Town or Location		10d. fnside City Limits				
	Mar de la la la la la la la la la la la la la	Maryland Car	roll	New Windsor		1X Yes 2 □ No				
	r 28a-f	10e. Street end Number	1011	10f, Zip Code	10g. Citizen of Wh	net Country?				
					yog. Silizon of the	iot oddiniy.				
	r tems 23s	2830 Graybill		21776		.s.A.				
		11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecity Yes or No-	- American Indian, White, etc.				
(0	T E E	1 Never Married 2 Married	1 ☐ Yes 2X No			Willia, Blo.				
215-0036	urs af	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	Specify:	White				
ö	be time	15. Decedent's E	ducation	16e. Decedent's Usual Occupation	16b. Kind of Busi	iness/Industry				
Ŋ	led within 72 hor lygiene *netura ne than *netura ne, the Medical E	(Specify only highest gr	ede completed)	(Give kind of work done during most of work life. DO NOT use retired)	ing	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
N	within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)	ine. DO NOT use remedy						
2	Hygier ther th	12	2	secretary		l government				
Þ	be file d oth event	17. Fether's Neme (First, Middle, Las	1)	18. Mother's Nam	e (First, Middle, Maiden Surname)	)				
ā	id be lented of ic even	Lloyd Robinson	_	He1	en Daniels					
$\geq$	2 should be filed volently be in and Mentel Hygie is marked other traumatic event, the To Be Co	19a. Informent's Name/Relationship		19b. Mailing Address (Street and Number or Rui		tate Zin Code)				
Maryland	2 s ia r									
	s 1 end 2 should be filed if Heelth end Mentel Hyg item 27 is marked other other traumatic event, To Be C	Marsha Compton/ d			ew Windsor, MD 2					
a.	T Se to	20a. Method of Disposition	Cerr	ee of Disposition (Name of netery, cremetory or other plece)	Date 20c. Location - Ci	ity or Town, State				
altimore,	permit. Peges 1 end 2 Depertment of Heelth e Important: If item 27 is any injury or other tra once.	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		County CremationServ.	1/22/09 Sykesyil	llo MD				
₩	permit. Pe Depertmar Important: any injury ance.	21. Signature of Funeral Service Lice		22. Name and Address of FecilityHar	tales Euposal He	me, 110				
Ba	Depe Impo	130	V1. 401							
	40 = # G	Tathanie ()	War/Der	310 Church St. N	ew Windsor, MD 2	21776				
		23a. Part . Enter the diseese, or con	plications they caused the deeth.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between				
	Physician	SHOCK, OF HEART TANDER. LIST OFFI	one cause-on each line.			Onset and Death				
	edical	Immediate Ceuse (Final	21-A	L R J						
	Examiner	disease or condition resulting in deeth)	· atheroscl	eratic freat dis	iceral	CLOSICE				
		, , , , , , , , , , , , , , , , , , , ,	Due to (or a	s e consequence of):		7				
	_ = q	_	ī.							
15	ding physician ending physician ending se es the buriel-transit	Sequentially list conditions.	Due to (or as	s e consequence of):						
0,	EX Set	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury								
68760,	certificate be ding physicia se es the bur	Ceuse (Disease or injury that initiated events	C	s e consequence of):						
8	phy sthe	resulting in death) Last	Due 10 (0) es	s a consequence or).		j				
×	ding se es		d.							
Bo	the tend									
	death ne etter ed for u	Part II. Other significant conditions	contributing to death but not resulting	ng in the underlying cause given in Part 1.	23b. Did tobacco use contr	ribute to the cause of death?				
P.0	The law requires that the death ocate has been signed by the etten paga 2 should be detached for u completed by Physician	77 1 5	101		1 ☐ Yes 2 ☒ No 3	3 ☐ Probably 4 ☐ Unknown				
	that the del	diabilion	allitus 14 pe	2						
ds	sign d	1.3	J,		24a. Was an autopsy	24b. Were autopsy findings				
ō	required hours	Fypertingue	777		performed?	available prior to completion of cause				
မ	as b					of death?				
Œ	The I				1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No				
<u>ra</u>	ifical or, p	25. Was case referred to medical		26 Place of Deep	th (Check only one) Choose	PRINCI Los				
of Vital Records,	Physician: this certific ral director,	exeminer?	Hospital:	Other						
of	hysic this caldire	1 Yes 2 No			ome 5 Residence 6 NOther 28d. Describe how injury occurred					
_	ng frer uner uner	1 Naturel 5 ☐ Pending	(Month, Dey Year)	Injury Work?	200. Describe flow injury occurred	u .				
Ö	Attending or death.  Sctor: After by the fune	2 Accident investigation		M 1 Yes 2 No						
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	spital or nours aft neral Di / filled in		nyelctan: To the best of my knowle	dge, death occurred at the time, date end place,		IIOI OS SIAIOU.				
	Hospital or 24 hours aft Funeral Di ataly filled in dical Cer			edge, death occurred at the time, date end place, n end/or investigation, in my opinion, death occur						
	o the Hospital or Attending P lithin 24 hours after death. o the Funeral Director: After to omplataly filled in by the funeral Medical Certification:	(Check only 2 Medical Exa	miner: On the basis of examination		red et the time, date and place, an					
		(Check only 2 Medicai Exa	miner: On the basis of examination	n end/or investigation, in my opinion, death occur	red et the time, date and place, an	nd due to the cause(s)				
)	To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Medical Cer	(Check only 2 Medicai Exa	miner: On the basis of examination	n end/or investigation, in my opinion, death occur	red et the time, date and place, an	(Month, Day, Year)				
	To the Hospital or within 24 hours aff To the Funeral Di complataly filled in Medical Cer	(Check only 2 Medicai Exa	miner: On the basis of examination and manner stated.	29c. License number	red et the time, date and place, an	nd due to the cause(s)				
	To the Hospital or within 24 hours aff To the Funeral Di complataly filled in Medical Cer	(Check only 2 Medical Example one)  29b. Signeture and title of certifier	miner: On the basis of examination and manner stated.  Completed cause of deeth (Item 2)	29c. License number	red et the time, date and place, an	(Month, Day, Year)				
)	To the Hospital or within 24 hours aft To the Funeral Di complataly filled in Medical Cer	29b. Signeture end title of certifier  30. Name end eddress of person who  31. Date filed (Month, Day, Year)	miner: On the basis of examination and manner stated.  Completed cause of deeth (Item 2)	29c. License number  29c DOOD 9 C ( 39) (Type, Print)	red et the time, date and place, an	(Month, Day, Year)				

**ORIGINAL** 

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PHYLLIS Month KLIMAN 10:20 P^M 2008 /Medical January 4 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital
5. Social Security Number 6. Sex 7. Age Olney Montgomery If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2√□ F 577-46-6751 76 Yrs. Director Nov. 11, 1931 <u>New York</u> Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring Blda. N 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 2901 S. Leisure World Blvd., United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 Û No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. White 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) **Aariculture** Biochemist permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jean Schwartz Abraham Greenberg ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert J. Kliman, Husband 2901 S. Leisure World Blvd., #401, Bldg. N, Silver 20c. LSchiffini-109 or TMD, Stat20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shaare Tefila Cemetery 01/07/08 Adelphi, MD 21. Signature of Funeral Solvice Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SOP 2000 all /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duc to (or as a consequence of). and The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as 23c. If yes, outcome pf pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 3 ∐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 3 Probably 4 Unknown DUKM On On 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate death? 1 ☐ Yes 2 Ø No 1□ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 hpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral dir 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 001165024 cause of death (Item 23a) (Type, Print) address of person who completed ca 18101 Prince Philip Dr., Olney, MD M.D., 31. Date filed (Month, Day, Year) egistrar's Signature State JAN 10 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 6, Day 2008 Year **Physician** Dorothy Elaine Keane 9:40P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4632 Quimby Avenue Beltsville Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Jan. 24, 1936 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 577-50-3215 1 □ M 2 💢 F 71 Washington, DC Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Maryland Prince George's Beltsville 1 ☐ Yes 2X No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4632 Quimby Avenue 20705 United States Funeral ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any lnjury or other traumatic event, the Medical I any lnjury or other traumatic event, the Medical I once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Processor Television/Radio 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Godfrey Muckelbauer Leota Eisenminger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4632 Quimby Avenue Beltsville, Maryland 20705 19a. Informant's Name/Relationship (Type. Print)

James E. Keane -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Metropolitan Crematory 1/9/2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald Vie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, living the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 N Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an has autopsy performed? ∕es 2€ No 1□ Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home St Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of after death. Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🐴 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or To the ... within 24 hours... To the Funeral Di 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) 1 0 2008 JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D41978

January 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** January 9, 2008 9:30A. Marcus Haysin Kahn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15115 Interlachen Drive, #215 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 9,1910 5. Social Security Number 160-01-0726 6. Sex **Funeral** Months Days 1XM 2□ F Pennsylvania Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits fshow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar," or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 15115 Interlachen Drive, #215 20906 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No White Specify Specify: ģ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0,12) College (1-4or-5+) Executive Clothing Manufacturer 17. Father's Name (First, Middle, Last) 18. Mcther's Name (First, Middle, Maiden Surname) Be Samuel Kahn Sophia Haysin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14316 Cantrell Road Silver Spring, Md. 20905 Bruce Kahn -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 □ Cremation 3 □ Removal from State Roosevelt Cemetery 1/11/2008 Trevose, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any 1-20 mg to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown þ cate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 XNo or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 【No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 After this 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury within 24 hours after used....

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital

State Registrar

31. Date filed (Month, Day, Year) 10 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certific



2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D08381

29d. Date signed (Month, Day, Year)

January 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day /Medical Muriel Isolde Kaiser-Kupfer January 9, 2008 9:45 P 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Liberty Assisted Living Potomac Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F Director New York 033-30-2134 May 25, 1936 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a 6016 Neilwood Drive 20852 Funeral United States of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Research Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ William Oscar Kaiser Muriel Delores Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Dr. Carl Kupfer - Husband 6016 Neilwood Drive, Rockville, Maryland 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 1/11/2008 Olney, Maryland 21. Sig. at re of P meral Service Ricensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Aspiration Pneumonia /Medical Due to (or as a consequence of) Examiner Dyscharia Sequentially list conditions, if any, leading to immediate cause. Litter bridering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Cerebral Vascular Disease and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical Parkinson's Disease as the asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XXUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2\(\sum No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify Group Home 2 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this in by the funeral : after death. 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and tit e of certifie 29d. Date signed (Month, Day, Year)

10

State Registrar

Dr. Susan Miller 11901 Georgia Avenue, Silver Spring, Maryland

31. Date filed (Month, Day, Year)

JAN 11 2008

32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D35579

1/10/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Joseph Edward Lester King /Medical 01 2008 1:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3841-A Memory Lane Abingdon, Maryland
Inder 1 Year If Under 24 Hrs. 8. Date Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Hours Director 220-54-7350 59 05/04/1948 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2 No Harford Abinadon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral 3841-A Memory Lane U.S.A. 21009 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4. Bace - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examine one. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 X No Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer State Roads Adm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Albert Lester King, Sr. <u>Margaret Kreutzer</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellinger (sister)
20a. Method of Disposition 11501 Stockdale Road - Kingsville Maryland 21087

pe of Disposition (Name of Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/23/2008 | Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P 21. Signature of Funeral Service Licenses 60 11750 Belair Road - Kingsville, Maryland assa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** bs tructive Viscase nronic monary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 No 1∐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 18/08 00060852 of person who completed cause of death (Item 23a) (Type, Print) BALTUMURE 9105 FRANKLIN SQ REDERICK K-WIL films, MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Theresa J. Larivee Jan. 2008 9:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1733 Fernham Ct. Crofton Anne Arundel If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
Aug. 9, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 □X 160-30-3395 Vermont 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 No Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1733 Fernham Ct. 21114 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1944-49 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurse medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Joseph Larivee Louise Vincent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Seidleck, Executor 12704 Kavanaugh Lane Bowie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 01/17/2008 Crownsville, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) werk Due to (or as a consequence of): f. brillarion - 427,31 +191 years Sequentially list conditions, if any leading to import cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of delivery Day Vear ute to the cause of death? ☐ Probably 4 ☐ Unknown re autopsy findings available or to completion of cause of ath? Yes 2 □ No (Specify)

**Physician** /Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

Director

Funeral

Completed by

Be

ပ

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marked.

Baltimore, Maryland 21215-0036

and

attending physician Physician/Medical Completed by Be Certification: Medical 24 To the

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery  Month Day Yea						
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk						
		24a. Was an autopsy autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 Residence 6 □Other (Specify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n ( <i>Montin, Day Year)</i> Injury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f.	Location (Street and Number or Rural Route Number City or Town, State)						

29b. Signature and title of certifier

29a. Certifier

(Check only one)

and manner stated

29c. License number

#220

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Gambrills, MD. 21054

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth K. Gallatin, M.D.

2401 Brandermill Blvd.

31. Date filed (Month, Day, Year)

JAN 1 4 2008

32. Registrar's Signature

State Registrar David Charles Lednum

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Marvlar	nd / Department	t of Health	and Mental	Hvaiene

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6	$\cup$	13	$\cup$		

		- For State		Cert	ificate of	Death				Reg. No.	201	J			
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middle,Las David Charles	st) 2. Date of De						eath Day	Year	3. Time of Dea 0733 hrs	th			
		4a. Facility Name (if not institution, given Race Street & Atlantic Av	4	b. City, Too Cambri		cation of Deat	th 4c. County of Death  Dorchester								
Funeral Director		5. Social Security Number 6. S			st birthday)	If Under Months		If Under 24Hr Hours Min		,	Fore	Birthplace (State of eign Countr Marvla	1		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  Maryland  10b. County  Maryland  10c. Street and Number  1402 Race St.  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify of Elementary/Secondary (0-12)  5  17. Father's Name (First, Middle, Last David Robert Lee  19a. Informant's Name/Relationship (12)  Leah Jeanine Wood  20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other Specify  2 Signs fire of Funeral Service Lee	12. Was Decedent I Armed Forces? 1 Yes 22 If Yes, Give Year or Dates: nly highest grade comm College (1-4 or 5) ednum  Type, Print ) Moth ward Lednu  Removal from Starsee	Ever in U.S.  No  No  Deted)  +)  ner  Im  Old'	13. Was If Ye 1 1 16a. Decedent during mo	mbric  10f. Zip C  2 b Decedent ss, specify  Yes 2 X  's Usual Or sst of worki  Stuc  Address  Race tion (Name er place)  'Churc ame and A	dge 21613 of Hispar Cuban, M No s ccupation ng life. Do lent 18. (Street al e St. e of cemet	nic Origin? (Sexican, Puert specify: (Give kind of O NOT use re  Mother's Nam  Leah  nd Number or , Camb  tery,  petery  Facility Facility  Tacing	Specify Yes or roo Rican, etc.)  work done titred)  work done (First, Middle Jeanine Rural Route Noridge, Date  1.21.20  Tuneral libridge	10g. Citize No- 12 Sy 16b. Kin e, Maiden St WOOC umber, City MD 2 20c. Lo 008 Ch Home	n of What Co  4. Race - Am White, etc. becify: Id of Busines  urname)  dward or Town, Sta 21613 ication - City hurch  PAA.	Dountry Ary Leaventry 10d. Inside Cit 1 X Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	y Limits No		
Physician /Medical raminer		a fart. Enter the disease or com- failure. List only one cause on e Immediate Cause (Final disease a or condition resulting in death)	olications that caused to ach line.  Multiple Injuries  Due to (or as a conse			e mode of	dying, su	ch as cardiac	or respiratory	arrest, shoci	k, or heart	Approximate Between Or Deat	nset and		
xecuted n and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that imitated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  d.												
	hysician/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	9 Olikilowii	time of dea	2 Fet	ner (Speci	fy)	Ectopic preg		N	Date of deliv	Day Y	/ear		
Records, P.C. The law requires that freate has been signed 1, page 2 should be deta	Completed by	Completed by	Completed by	Part II. Other significant conditions	contributing to death	but not re	sulting in the u			en in Part I.	1' 24a. W. au pe 1 <b>V</b> Ye	Yes 2 🗸	No 3 F		nknown available
'ital sician is certi	ŭΙ	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatient		101	hor.	sing Home 5	Residen	ce 6 🗸 O	her: Scene			
n of V ding Phys h. After thi	on: 10	1 ✓ Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day You Jan 17, 2008	ry T	28b. Time of It 0728 hrs		Bc. Injury	at Work?	28d. Descrit Pedestria	e how injur	y occurred				
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	2 Accident Investigat 3 Suicide 6 Could no determine	ation 28e. Place of Injury - At home, farm, stree			et, factory,	1 Yes 2 ✓ No factory, office building, etc.			28f. Location (Street and Number or Rural Route Num or Town, State) Race Street & Atlantic Avenue, Cambridge, MD					
To the Hospil within 24 hour To the Funer completely fill	<u> </u>	29a. Certifier (Check only 1 Certifying Physic	ian: To the best of my r:On the basis of exar and manner stated.	/ knowledg	e, death occur				nd due to the c	ause(s) and	manner as s	tated.			
F 3 F 8	ğ	29b. Signature and title of certifier	and manner stated.			29c.	License r	number	-	29d. D	ate signed (	Month, Day, Year)			
		John Je 30. Name and address of person who	Les m		23a)		O.C.M.	.E.		Janu	ary 18, 20	008			
į			Assistant Medica			Penn St	reet, B	altimore, N	/ID 21201						
Sta Registr		31. Date filed (Month, Day, Year) 200	8 32 Registrar	's Signatu	re Appar							``			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month РМ /Medical Luvenia A. Miller January 18 2008 1424 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Hospital E1kton Cecil If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Director 220-24-0087 AUG 28, 1930 Maryland Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Directo 1 X Yes 2 □ No Pennsylvania Chester 0xford 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or be Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be not 213 Valley Avenue 19363 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates; 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State Government Elementary/Secondary (0-12) College (1-4or 5+) Claims Processor Department of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jones ၉ Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie A. Miller/Daughter 213 Valley Avenue, Oxford, PA 19363 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; If Itel
any injury or ott 20c. Location - City or Town, State January 22 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 2008 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 man 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRANCE CARDO HOURS /Medical Due to (or as a consequence of): Examiner A. Pubrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPERTENSION YEMUS Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria preunonia Physician/Medical DAYS 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year ned by the at detached for 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Michael Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 2 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065733 P.V. Nayou D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARAYANA RAS. PULA 118 NORTH SMEET SWILL 3B, ECKTON, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. -2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** January 6, 1:30 P M 2008 Muriel Moore /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Yrs. 091-16-9315 85 Feb.3,1922 New Director York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Montgomery 1 X Yes 2 ☐ No Rockville Md. Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20850 USA 9701- Veirs Drive 238 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2X Married Maryland 21215-0036 ٥ 1 ☐ Yes 2 No Specify: White ₹ 3 Widowed 4 Divorced 'natural'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 4 Yrs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event 9DCS. Julia Pons Frank Marcosano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7512 Granada Dr., Bethesda, Md. 20817 Robin Moore Kurtzman-Daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mctropolitan Crematory 1/8/2008 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2222-Wisconsin Ave., NW W. Hysony Co., Inc. Washington, DC 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Casa /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transit Due to (or s consequence of) Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 5 obs tructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 ☐ Yes 2 7 No 1 ☐ Yes 2 2000 of Vital To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at' Work? Certification: Division 5 Pending investigation 1 A Natural death. 1 TYes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide after To the Hospital o within 24 hours aff To the Funeral Di 23s Certifier 🔀 Certifying Physiciam To the best of my knowledge, death conured at the time, date and plane, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Mile of certifier 29d. Date signed (Month, Day, Year) 00050612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701- Vairs Dr., Rockville, Md. 20850 Dr. Samuel Maller 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

		•	For State Registrar		С	ertificat	e of i	Death			Reg. No. 2	008	0196																
	Dhyalaid		1. Decedent's Name (First, Middle, La	st)					2	2. Date of De Month		Year	3. Time of Death																
Or	Physicia /Medic	_	DELORES		MOORE				ام	Tanko		1008	11:260																
	Examin		4a. Facility Name (If not institution, giv DOCTORS HOSPITA	L	(l	LA	NHAM	Location of		P. Date of Bir	PRIN		OEGE'S																
Ì.	Funeral Director		5. Social Security Number 6. S 578–46–4036  Usual Residence of Decedent	CIM OKIC	73 Yrs	Months	Days	Hours	Min.	B. Date of Bir (Month, Da 1ARCH	30 1934		INGTON, DC																
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on or	on the hospital of Artending Physician; The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	ry 28b. Tim		28c. Inju Wo	4 LJ Nur	2		how injury occ		пу)																
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 1:35am **Physician** Jan. 7,2008 Grace F. Muhawi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda 8706 Hartsdale Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days Min 7/102th 1999 214-98-4511 1 M 2 T 48 Jordan Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Intit if item 27 is marked other than "natural", or items 23a or 28a-f show riny or other traumatic event, the Medicial Examiner must be notified at my or other traumatic event, the Medicial Examiner must be notified at 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County Bethesda 1 ☐ Yes 2 ☐ No Md Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 USA 20817 8706 Hartsdale Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than the M College (1-4or 5+) Elementary/Secondary (0-12) Development Co. Executive Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nuha Y.Kaibni Farhat J.Muhawi 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Antony Ho/Husband 8706 Hartsdale Avenue Bethesda, Md 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Ma Burial 2 ☐ Cremation 3 Removal from State Gate of Heaven Cem. 1/11/2008 Silver Spring, Md 4 ☐ Donation 5 Other (Specific 21. Signature of Funeral Service Los PHILIPADS PINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical attending p IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à q 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 卢 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: hours after death. filled in by completely within 2.

2

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of certified

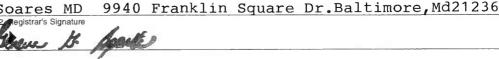
29a. Certifier

Corazon Vergara-Soares MD 31. Date filed (Month, Day, Year) JAN 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

achours/ NO

and manner stated.



1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D16619

29d. Date signed (Month, Day, Year)

Jan.7,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Physician January 11:50 PM Gracie С. McAuley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Ijamsville 3040 Averly Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F South Carolina 88 May 01, 087-18-9082 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 TX No Director 0cala Florida Marion 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 34476 United States 11117 SW 79th Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🗙 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Black þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Retail Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) h and Mental F Be Minnie Wiggins 2 Jones Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 James McAuley / Son 3040 Averly Road, Ijamsville, MD 21754 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 1/8/2008 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1030 Rockville Pike, Rockville, MD 20852 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final Physician **Physician** Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Metastatic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 : autopsy performed? 1□ Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Date (Specify) Son s Home 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No death. i Director: A 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide ō within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 일 D0055864 January 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Collier, M.D. 10215 Fernwood Road Ste. 303, Bethesda, MD 20817 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Barbara Ellen Myerly Yanuar y 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital orchest Cambridge 8. Date of Birth (Month, Day) 1940 Mary Land If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 67 Yrs. 5. Social Security Number **Funeral** Days 1 M 2 SF Min. 216.38.9390 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Maryland Linkwood 1 ☐ Yes 2 No Dorchester r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3640 Karen Circle 21835 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) private duty nurse health care Department of Health and Mental Hygis Important: If Item 27 is marked other I any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Granville S. Shorter Murial Elizabeth Airey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3640 Karen Circle, Linkwood, MD 21835 Roy Franklin Myerly, Jr./Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DorchesterMemorialPark1.21.2008 Cambridge, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funer I Solice Licensee Curran-Bronwell Funeral Home, P.A. 308 High St., Cambridge, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia nous **Physician** /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transi and Due to (or as a consequence of) physician Physician/Medical the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Xyes 2 No 3 Probably 4 Unknown Completed daleto 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 s autopsy performe death? certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 2 funeral 28b. Time of Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending

To tro.
within 24 hours a.
To the Funeral Director the

> State Registrar

Medical

29a. Certifier

29c. License number 6 40 43

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195. Washington St. Easton, M Monte

32. Registrar's Signature

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Deatl 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Rose Evelyn Nugent 12:55 P M January 8, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville
If Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🖵 F Yrs. 1930 Washington, DC Sept. 6, Director 578-36-1919 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show Items 23a or 28a-f shorner must be notified at 1 ☐ Yes 2 No Maryland Silver Spring Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 3453 Chiswick Court, Apt. 1A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Examiner filed within 72 hours after 1 ∏Yes 2√√No If Yes, Give 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d other than College (1-4or 5+) Elementary/Secondary (0-12) traumatic event, the Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Eleanor Myrtle McLaughlin Daniel Raymond Tassa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3453 Chiswick Court, Apt. 1A, Silver Spring, MD 20906 Paul E. Nugent/Husband f Health Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. Date 12, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 21. Signature of Funeral Service Ligenses 22. Name and Address of Facilit Francis J. collins Funeral Home Inc. Keekard L Giles 500 University Blvd, W., Silver Spring, Md 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Advanced Chronic Obstructive Pulmonary Disease physician and the burial-tran Due to (or as a consequence of): Box 68760, Congestive Heart Failure Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Lung Cancer, Chronic Kidney Disease 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? 1∐ Yes 2√ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 2FLNo Certification: To 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation Injury M 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D64478 January 9, 2008

State Registrar

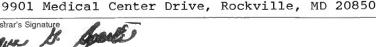
31. Date filed (Month, Day, Year) 1 0 2008

Fisehatsion Mehari, MD

30 Name and address



of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Ozag, Sr. P M 4:24 1/17/2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, June 12, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1931 Pennsylvania 196-22-8816 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State a or 28a-f show t be notifled at 1 □Yes 2 No Maryland Frederick Frederick Director 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. U.S.A. 21702 8203 Greenvale Drive Items 23a Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items edical Examiner m Black White etc. 1 Pes 2 No If Yes, Give 949-1953 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Medical College (1-4or 5+) other than Elementary/Secondary (0-12) Board of Education Supervisor/Human Resources the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental i Catherine Miller Stanley Ozag, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8203 Greenvale Drive, Frederick, MD 21702 Mrs. Barbara L. Ozag, wife Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery Jan. 21, 2008 Frederick, MD 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Keeney & Basford P.A. 21. Signature et Funeral Service Litensee 106 East Church St. Frederick, MD 21701 MO0255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Years **Physician** ASCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Years Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown Colon Cancer 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes XX No Deep Venus Thrombois 24a. Was an Was ...
autopsy
performed?
Ves 2 XIXIo 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2XER/Outpatient 3 □ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural funeral 28b. Time of To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? 28d Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Hornicide La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marner stated. 29a. Certifier Medical

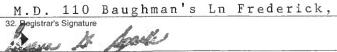
or Vital Records, P.O. Division

Baltimore, Maryland 21215-0036

State Registrar

Dr. Julio Menocal 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D 31912

29d. Date signed (Month, Day, Year)

21702

MD

			1 - For State Registrar	ate of Marylar	nd / Depa <i>Cei</i>	artment rtificate	of H	ealth a Death	and M	ental		ne No. 2 (	008	01970
F	Physici	an	Decedent's Name (First, Middle, Last)					_		2. Date of Month		Day	Year	3. Time of Death
-	/Medic	al	HARDEN PARKS	1 - 1 1		4h City T		l continu	f Dooth	JAN		40. Count	2008 y of Death	11:15 P M
13	Examin	er	4a. Facility Name (If not institution, give stree	and number)			VEYLD	Location o 4 <i>LE</i>	i Deam				_	EORGES
	Funeral		Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under	-	If Under 2	24 Hrs. Min.	8. Date of	of Birth		9. Birthp	lace (State or Foreign
Ш	Director		241-18-7114 X	^{2□ F} 86	Yrs.	MOTHERS	Days	riouis	IVIIII.	DEC	$\stackrel{\scriptscriptstyle h,\; Day,\;\; Ye}{16}$	921	SOUT	H'CAROLINA
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	Mary -f sho fied a	to	DC	Į Į	JASHING	TON								Y Yes 2 No
	or 28a	irec	10e. Street and Number			10f. Zip	Code				10g.	Citizen of	What Coun	try?
	ath wit	ral	832 TAYLOR STREET	N.E. # 4			017					USA		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	Vas Decedent Ever in U urmed Forces? X∫Yes 2 ☐ No Yes, Give ear or Dates:		Was Decede If Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto l	ecify Yes o Rican, etc	or No- .)		ice - Americ ack, White, ify:	
2-0	72 ho natur diral I	eted	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Deced	dent's Usual kind of work DO NOT use	l Occupa k done d	ition uring most	of worki	ng	16b	. Kind of B	Business/Ind	lustry
121	within lene. than " he Med	Completed		College (1-4or 5+)		DO NOT use CHANI						PR	IVATE	
d 2	e filed within al Hygiene. I other than ' vent, the Me		17. Father's Name (First, Middle, Last)		FIL	OIMIL		18. Mothe	r's Name	(First, Mi	ddle, Maid			
lan'	should be ind Mental i marked c	To Be	GRANT PARKS						ESS	SIE	PERDU	JE		
ž	1 and 2 shou Health and M em 27 is mar other traumat		19a. Informant's Name/Relationship (Type. F MAXINE MEANS/NIECE	Print)	19b. Mailir 1706	ng Address BASHF	(Street a ORD	nd Numbe LANE	GREI	I Route N ENSBC	RO, NO	y or Town ORTH	n, State, Zip CAROL	Code) INA 27405
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐∰Purial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	Place of Dispo cemetery, crer OCK CRE	natory or oth EK CE	her place METE	RY	1/15/	oate 12008	WAS	SHING	- City or To	С
Balt	permit. Departimport Import any inj		21. Signature of Tineral Service Uconsee			2. Name and 174 LA								OME 20785
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused the dea	th. Do not ent	er the mode	of dying	g, such as	cardiac o	or respirate	ory arrest,			Approximate Interval Between Onset and Death
	hysician		Irmmediate Cause (Final disease or condition resulting in death)	METACTAT		TATE	CA	NCER	_					3 years
magnetic land	/Medical Examiner		resulting in detail)	Due to (or as a consec	quence of):									·
500		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):									
	cuted nd ransit	Examiner	that initiated events											
8760,	e exe cian ar urial-t		resulting in death) Last	Due to (or as a consec	quence of):									
876	cate be executed physician and the burial-transit	dica	d		_									
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the law requires the transmission and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months?	yes, outcome pf pregn □Live birth 2 □ Fet □ Pregnant at time of □ Unknown	al death 3 □	Ectopic pre Other (spe						1	ate of delive	ery Day Year
, P.O	that the by detac	/ Ph	Part II. Other significant conditions contribu	ting to death but not re	sulting in the u	nderlying ca	use give	n in Part I.		23e.	Did tobacc	o use con	tribute to th	e cause of death?
Records,	quires n sigr uld be	ed by									1 🗌 Yes	2 100	3 🗌 Prob	ably 4 □Unknown
ဝ၁	aw re	plete						_			Was an autopsy	24b.		psy findings available inpletion of cause of
Œ	The arte has page	Completed								1 Y	perform <u>ed</u>	? <b>₹</b> 16	death?	2□ No
i Ka	lcian; certific ector,	Be	25. Was case referred to medical examiner?	tal:			Othe	26. Place	of Death	(Check c	nly one)			
ō	Phys r this ral dir	.T	I  162 5 140	a. 1 ☐ Inpatient 2 ☐	ER/Outpatien		A	4 MINU			Residence		her (Specify	/)
o	nding th. : After e fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	Bc. Injury Work 1 □ Y	? ′es 2 🗆 1		200. 5000		ijary ocea		
Division or Vital	after dea after dea Director	Certification:	o□ outside	Be. Place of injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory,	, office		2	28f. Locati City o	on (Street r Town, St	and Num ate)	ber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of my kn On the basis of examin and manner stated.	owledge, death ation and/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a	and due to	the cause ime, date	e(s) and m and place	nanner as si	ated. the cause(s)
•	To the within To the compl	Me	29b. Signature and title of certifier  M. D.			29c.	License	number 2591	4			_	ed (Month,	Day, Year) 10,2008
	1/5)		30. Name and address of person who comple					4.4		0	12-			
	0		4409 EAGT-WEST	HUHWAK 32. Registrar's Sign		ENDALE	, n.	412414	UD	200	5/			
	Sta Registr	-	JAN 1 4 2008	32. Hegistrar's Sign										
Dilli		001	DAM T # FOOD	w Is Ap										

**Funeral** Director 28a-f show the ō death with Items 23a Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 ō 'natural' other t n and Mental H permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once. Physician /Medical Examiner

Box 68760.

Division or Vital Records, P.O.

The law requires that the death certificate be executed the or Attending Physician: Director: Hospital within 24 hours a

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician**  $a^{\,\text{M}}$ 2008 Rita Frances Powell 7, 11:30 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Hours 78 3, 578-34-7993 Dec. 1929 Washington, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 □Yes 24□No Director Maryland Cabin John Montgomery 10n. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6501 76th Place 20818 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ⅓ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 ☑ No Specify. þ Specify: White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Financial Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reginald Paul Fitzgerald Catherine Frances Moloney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen H. Gallagher/Daughter 5 Tydings Road, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 11, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2008 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License falab 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a Asystole Due to (or as a consequence of): b. Respiratory Failure Sequentially list conditions, if any, leading to immediate cause Lines Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Pulmonary Fibrosis that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2□ No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 1- Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🏗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65478 January 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Sanaei Ardekani, MD 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JAN 1 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:40 AM Norman William Price. Sr. AS, ACOB 4c. County of Death Jenusty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner A Maryland Health Come 5 ecil Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 11. 205-22-3033 79 Sept. 1928 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Meral Hygene. Important: If time 27 is and Meral Hygene. Important: If time 27 is an arked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 No Be Completed by Funeral Director Havre de Grace Maruland Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 U.S.A. 134 Green Street 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, et 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1950-1 ☐ Yes 2 No White. 3 Widowed 4 Divorced 1956 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Price Trene Hummer 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley R. Price (Wife) 134 Green Street, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Gardens 1/25/2008 Aberdeen, Maryland 21. Signature of Funda Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** UNKUSWI /Medical Due to (or as a consequence of): Examiner POPOPO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No ensentia 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number Pennsylvano 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene, For State Registre Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 17, 2008 ear MAT. **Physician** 8:35 A M DELORES VIRGINIA PICKERAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES GENESIS LA PLATA CENTER LA PLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 66 213-46-6105 Yrs. 2-3-1941 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow other treumatic event, the Mudical Examiner must be notified at 1 XYes 2 No INDIAN HEAD CHARLES Director MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 20640 U.S.A. 5360 NELSON POINT RD. or iteme 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ▼No þ 3 ☐ Widowed 4 ☐ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then College (1-4or 5+) OWN HOME HOMEMAKER Pages 1 and 2 should be filed witness of Health and Mental Hygientent: if item 27 is marked other thiury or other treumatic event, ILL 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AGNES VIRGINIA JOHNSON JOSEPH ROY HAWKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20616 JAMES HENRY PICKERAL, JR .- SPOUSE 2207 HEATHER LN. BRYANS ROAD, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) ME permit. Page Department ( importent: if eny injury or METROPOLITAN CREMATORY 1-23-08 ALEXANDRIA, VA. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee M00479 Me 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Begin Concer Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 XNatural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 | Yes 2 | No death. To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 00061652 use of death (from 23a) (Type, Print) 550 Pembrooke Sgave, waldoof 30. Name and additional state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o 1135 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 anuary Florence Elaine Towles Rosser /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Doctors Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Davs Hours Min 1 ☐ M 2 🔀 F Yrs. 75 11/14/1932 Washington, DC Director 578-42-6662 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Exminer must be notified at any Injury or other traumatte event, the Medical Exminer must be notified at 1 Yes 2 □ No Director Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 20743 U.S. 914 Booker Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Afro-1 ☐ Yes 2XX No Specify þ Baltimore, Maryland 21215-003 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Public Schools Teacher Pages 1 and 2 should be filed went of Health and Mental Hygic ant; If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Thelma Freeman Robert W. Towles ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hus 914 Booker Dr., Capitol Heights, MD 20743 /band John R. Rosser, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/10/08 Beltsville, MD Chesapeake Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc 7400 Georgia Ave., N.W. Washington, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 12/1/150 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2010 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Thpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Phospital or Attending Plant St. Abours after death.

Funeral Director: After ti 27. Manper of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
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Lillie	Bell	Rowe

08-00259 Lillie Bell Rowe		State of	Maryland / Depar	tment of I	Health a	nd Menta	al Hygie	ne			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		T \ \ \ \ A \ \ \ \ \ \ \ \ \ \ \ \ \ \	1) / 1 / ( 1 1/	74	474 LA	NDOVER	ROAD 1	LANDOV	ER, MD	2078	Approximate Interval
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<u>id</u> 8 <b>5</b> 5	Cortification	4 Homicide determin	, , , , , , , , , , , , , , , , , , , ,		coursed at the	time date and		due to the c	ause(s) and ma	nner as s	stated.
e Hos n 24 h ie Fun	1 /98. Certife : — Physician: To the hest of my knowledge, death occurred at the time; and										
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	January 10, 2008										008
(3)		30. Name and address of person wh	no completed cause of death (	1( 23a)	<b>2</b>			J. 372			
Gr	1	Theodore M. King, Jr., N	ID. Assistant Medica	al Examiner	111 P	enn Street,	Baltimore	e, MD 212	201		
	Sta	D4 Date filed (Month Day Year)	32. Registrar's Sig								
Barr	ich	<b>昻 JAN 1 4 6000 /</b>	Was I K A	make a							

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

State

Registrar

**JAN 14** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Amend Item	25 per me, g	876,02/	94:108 11 b	Death	nemai my	Reg. No 200	8 01977
g	Physici	an	Decedent's Name (First, Middle, La	ust)				2. Date of Dea Month		3. Time of Death
	/Medic		Pauline F. Rees					January	3, 2008	3 1:00 p ^M
	Examir	er	4a. Facility Name (If not institution, given	,		4b. City, Town, o	r Location of Death		4c. County of	Death
100			Shady Grove Adverse. Social Security Number 6.8			Rockvi	11e	1000	Montgo	
	Funeral			1 □ M 217 F	yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birti (Month, Da)	y, Year)	Birthplace (State or Foreign Country)
М	Director		Usual Residence of Decedent	8	1			Sept. 1	3,1926   0	hio
	/land ow		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Mary -f sh fied	ţ	MD Montgom	erv	Rockvill	۵				1 □ Yes 2X No
	r 28a	Director	10e. Street and Number	or y	ROCKVIII	10f. Zip Code			10g. Citizen of Wha	at Country?
	h with	읖	303 Adclare Road			20850			USA	Δ
	deat	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race -	American Indian,
9	after or ite mine		1 ☐ Never Married 2 ☐ Married	1 □Yes 2 No		1 ☐ Yes 2 ☑ No	an, mexican, Puerro  Specify:	Hican, etc.)		White, etc.
215-0036	J be filed within 72 hours after death with the Maryland ntal Hygiene. d other than "natural", or items 23a or 28a-f show e event, the Medical Examiner must be notified at	d by	3 Nidowed 4 □ Divorced	Year or Dates:		TEL 163 ZAL 160	эреспу.		Specify:	White
ر ک	72 h "natu dica	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of work	king [	16b. Kind of Busin	ess/Industry
2	vithin ne. han	ш	Elementary/Secondary (0-12)	College (1-4or 5+)						
7	e filed within 72 P al Hygiene. I other than "natu vent, the Medica	ပိ	17. Father's Name (First, Middle, Last	4	<u>  Eler</u>	nentary Sc				lic Schools
	ntal hed of	Be		,				, , ,	Maiden Surname)	
Ž	should band Ment and Ment s marked umatic o	၉	Cecil W. Fryman  19a. Informant's Name/Relationship (	Tiron Print)	10h Mai	ling Addrona (Street	Allie Lo			
<u>s</u>	d2s than t7 Is I			,		ing Address (Street				
ď,	es 1 and 2 should b of Health and Ment tem 27 Is marked r other traumatic e		Mr. Steven R. Ree 20a, Method of Disposition		Db. Place of Disc	North St	i	Date	S, Unio 4 20c. Location - Cit	
altimore,	ages ant of t: If II y or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		•	ematory or other plac	í			•
	artme ortan injur		21. Signature of Funeral Service Lice	· ·		coln Crema 22. Name and Addre		9/2008	Brentwood	d, MD
n	permit. Pages 1 Department of F Important: If Ite any injury or ot once.		MSG		1.5	Simple Tri	bute Fund	eral and . Rockvi	l Crematio	on Center yland 20852
			23a. Part1. Enter the disease, or com shock, of heart failure. List only	plications that caused the one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a_Intercran						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor				,	1/	
	Examine	_	Sequentially list conditions.	b				- At	MINER	
	sit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of):		0 0	TO BY MEDICA	TENO	
	xecut and II-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):		TONIAPPR	KONED		
2	be e sician buris						CERTIFICATIONAPPE			
08/00,	certificate be executed ding physician and ise as the burial-transit	Medical		d						
×	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pro					23d. Date o	f delivery
200	w requires that the death ce been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 🂢 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic pregnancy □ Other <i>(specify)</i> _	/ 		Month	Day Year
<u>.</u>	t the	hys	9 Unknown	9□Unknown		1,7				
7.	The law requires that the ate has been signed by the page 2 should be detache	by P	Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
cords,	equire en sig			······			<del></del>	1 □ Y	'es 2 □ No 3 □	☐ Probably 4X Unknown
) 1)	aw re as be	Completed						24a. Was a		e autopsy findings available
	The ate his	mo						autop: perfor 1∐ Yes	med? deat	r to completion of cause of th? Yes 2 ☐ No
מש	ctor,	Be	25. Was case referred to medical examiner?				26. Place of Death			163 2 10
5	hysic his ce I dire	2	1 X es 2 No	Hospital: 1 💢 Inpatient	2 ☐ ER/Outpatie	nt 3□ DOA Oth	er: 4 ☐ Nursing Ho	me 5 Resid	ence 6 □Other (	Specify)
=	ding Physician: The lav. h. After this certificate has funeral director, page 2		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time (	of 28c. Injur World	y at k?	28d. Describe h	ow injury occurred	
2	tend leath. tor; / the fi	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
<u> </u>	lor Al after o Direc	Certification:	4 Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (S City or Town	treet and Number on, State)	r Rural Route Number,
	ospita hours ineral		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, dea	th occurred at the tir	ne, date and place,	and due to the o	cause(s) and manne	er as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical	one) 2   Medical Exam	niner: On the basis of exar and manner stated.	mination and/or i	ovestigation, in my o	pinion, death occur	red at the time, o	date and place, and	due to the cause(s)
1	5. <u>₹</u> 5. g	-	29b. Signature and title of certifier	1		29c. License	e number	2	29d. Date signed (M	fonth, Day, Year)
	4		· Melly M	an D. C	) _	D6618	39	J	January 3	, 2008
	Pare		30. Name and address of person who			•	1	Manage 1	1	
	Stat	6-	Meena G. And yew 31. Date filed (Month, Day, Year)	9901 Medical 3 Registrar's S	ianatura		kville, l	naryiano	1	
	Registra	_	JAN 1 0 20		K 60	anti)				

			For State Registrar	State of Marylar		artment of F rtificate of I			giene Reg. No. 2	08	01978
25	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of Death
	/Medi	cal	Roy Randol  4a. Facility Name (If not institution, give st		III	4b. City, Town, o	r Location of Death	Jan./	2008	y of Death	3:05а м
A.			Laurel Regiona			Lauı			Pri	nce (	George's
*	Funeral Director			7. Age (In yrs. 53	(last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	^h 1 ^y 9'5 4	9. Birthp Cour Wash	place (State or Foreign ntry) D.C.
	aryland show	,	Usual Residence of Decedent  10a. State 10b. County  MD Howard		ty, Town or Lo aurel	cation				1	10d. Inside City Limits 1 ☐ Yes 2X No
	ith the M or 28a-f	Direct	10e. Street and Number			10f. Zip Code	7.2.2		10g. Citizen of		
	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director		2. Was Decedent Ever in U Armed Forces?	J.S. 13.		723 ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	JSA ce - Americ	
9030	nours afte ural", or i	by	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		I∐Yes 2∭XNo	Specify:		Specia	r	White
Maryland 21215-0036	/ithin 72 } ne. han "nat e Medica	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)		dent's Usual Occup kind of work done o DO NOT use retired nauffeui	ation during most of work d)	ing	16b. Kind of B		ne Co.
Z	illed Hygi ther nt, t	Be Co	17. Father's Name (First, Middle, Last)	<u>Z</u>	U.	naurreur	18. Mother's Name	e (First, Middle,			ie co.
ylan	should be filed and Mental Hygi s marked other umatic event, t	To B	Roy Randolph Re					cia A.			
	s 1 and 2 should if Health and Mer ttem 27 Is marke other traumatic		John Reed/Broth				and Number or Rur shead Re				code)20904 ring,Md
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place ake Cref		2008	20c. Location	•	•
Balti	permit. Page Department Important: If any injury or once,		21. Signature of Tunda Service Licensee	Ludos	P	Name and Address		FUNER	RAL SE	RVICI	E,P.A. g,Md20910
ľ	j		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the deat cause on each line.					^	JI III	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Respirator Due to (or as a consequence)		lure					Onset and Death
	Examiner		Sequentially list conditions. b.	Pulseless	elect:	rical ac	ctivity				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Low blood	press	ure					
,09/80	ificate be executed j physician and as the burial-transit	al Exa	resulting in death) Last	Due to (or as a conseq	uence of):				_		
	ertificate ing phys as the	Medical	IF FEMALE:								
о. Вох	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3 □	Ectopic pregnancy Other (specify)				te of delive onth	ery Day Year
χ. Γ	requires that the een signed by the rould be detache	þ	Part II. Other significant conditions contr	ibuting to death but not res	ulting in the un	derlying cause give	en in Part I.				ne cause of death?
ecords,	s been s	Completed						1 □ Y			pably 4 Unknown
r	n: The law ficate has be		as Was					autops perfor 1⊟ Yes	sv	prior to cor death? 1 ☐ Yes	mpletion of cause of
	nysicia nis certi directo	To Be	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	spital: 1 <b>⊠</b> Inpatient 2 □	ER/Outpatient	3 DOA Othe	26. Place of Deather: 4 □ Nursing Ho	`		er (Specifi	
0	ding Pt h. After th funeral		27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. İnjury Work		28d. Describe h			<u>/</u>
UNISION	I or Atten after deat Director: I in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre			28f. Location (S. City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 ☑ Certifying Physic 2 ☐ Medical Examine	cian: To the best of my knoer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cred at the time, c	ause(s) and madate and place,	anner as st and due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License			29d. Date signe		
	4		30. Name and address of person who com	pleted cause of death (Item	1 23a) (Type, F	Print)	0645	39	Jan.	2,200	J &
	Sta	9	Srilatha Kanumu 31. Date filed (Month, Day, Year)	32 Aprietrar's Signa	turo		sen Rd I	aurel,	Md 20	707	
	Registra		JAN 1 0 2008		y April	uli					
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Registrar DHMH 17 Rev 1/2001

Physician   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   Medical Examiner   M	ual Residence of Decedent a. 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Mother's Namber or Riet, Whea	Specify Yes or Noto Rican, etc.)  March 1  Specify Yes or Noto Rican, etc.)  Arking  Int  Int  Int  Int  Int  Int  Int  I	7, 2008 4c. Could have year) 4, 1919  10g. Citizen US  0- 14. [ Special Sum Real A. Maiden Sum Per. City or Tot 0902  20c. Locatic Lortor	Montgo  9. Birth Cou Virgi  of What Cou SA  Race - Ameri Black, White, secifyWhit of Business/Ir	mery place (State or Form nity) nia  10d. Inside City Lim 1 Yes 2 1 intry? can Indian, etc. e industry							
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State 10b. County  aryland b. Street and Number 11001 Dayton Street  Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest of Elementary/Secondary (0-12)  Father's Name (First, Middle, La Daniel Reid  a. Informant's Name/Relationship ones L. Reid/Wife b. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify One) Signal re of Fineral Service Li.  A. Part 1. Enter the disease, or conshock, or heart failure. List on mediate Cause (Final ease or condition)	Montgomer  Teet  12. Was Dec Armed For 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In y. 88  10c.  y  Seedent Ever in orces? 2 \( \text{No} \) No ive Dates: 194  1-4or 5+)  State  Po	Yrs.  City, Town or L  W  10.S. 13.  2-45  16a. Dece (Give life.)  19b. Maili  1100  Place of Disportant Church Church  F. 50	Si.  Si.  Si.  Si.  Si.  Si.  Si.  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30.1	Name and address of person who	no completed cause	e of death /It	em 23a) (Type	Print1	2023	-20		<del>ไว</del> ทมลา	v 8, 2	208							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 8, Day 2008 Year **Physician** MARGARET SMITH RIDER 12:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANDRIN CHESAPEAKE HOSPICE HOUSE HARWOOD ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
OCTOBER 8, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖫 F Months Days Hours Min 85 492-32-3605 FLORIDA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 No **OUEEN ANNE'S** MARYLAND STEVENSVILLE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 810 BAYSIDE DRIVE 21666 UNITED STATES Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No 1945-If Yes, Give Year or Dates: 1946 be filed within 72 hours after ntal Hygiene. 1 □ Never Married 2 □ Married ö Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify þ 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than STATE HOSPITAL DIETITIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l and 2 should be fi fealth and Mental H Be Is marked FRANK SMITH HALLEY LEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat 810 BAYSIDE DRIVE, STEVENSVILLE, MARYLAND 21666 SUE MCLEAN/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State CROWNSVILLE VETERANS CEMETERY 1 X Burial 2 ☐ Cremation 3 Removal from State JANUARY 10, CROWNSVILLE, MARYLAND 4 Donation 5 Other (Specify) 2008 FUNERAL HOME, P.A. 106 SHAMROCK ROAD NEWNAM 21. Signature of Funer Service Licens CHESTER, MARYLAND 21666 23a. Parti. Enter shock, or he or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hear failers. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Reen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö ed by the 9 Unknown 9 Unknown signed by t Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy page certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be MANDRIN Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending H)USI 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after vithin 24 hours
To the Funeral Discompletely filler 1.2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29b. Signature and title of cartifier. 29d. Date signed (Month. Day, Year) 21438was **JANUARY 8, 2008** 30. Name and address of pars in who completed cause of death (Item 23a) (Type, Print) MICHAEL LAPENTA, M.D., 445 DEFENSE HIGHWAY, ANNAPOLIS, MARYLAND 21401 31. Date filed (Month, Day, Year) 32 egistrar's Signature - 9 2008 JAN Registrar

			For State Registrar	State of M	laryland / Depa	artment of F		and Mental		$-2 \Pi \Pi \Omega$	01981
	$\Omega_{\mathrm{op}}$	ŷ.	Decedent's Name (First, Middle)	Last)		Timoato or I	Douin	2. Date	Reg. No		3. Time of Death
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	/Medic Examir		4a. Facility Name (If not institution,			4b. City, Town, or	r Location of			. County of Deatl	11:00 A "
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ь	Director	8	219-20-1768	10 W 2 1	81 Yrs.			Oct.			yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	igton	Hagerstow	10f. Zip Code			10g. Cit	izen of What Co	untry?
	th with		2003 Maplewood 1	Or.		21740			U.S	. A .	
	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	gin? (Specify Yes		14. Race - Amer Black, White	
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5-0036	hours tural'	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	T Contract	d#- HI O	-47			W	nite
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717	withi	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	1 Princip			Con	nty Gove	a serom on t
0	e filed Il Hygi other ent, tl	BeC	17. Father's Name (First, Middle, L		SCHOO	T T T T T T T T T T T T T T T T T T T		er's Name (First, M			eriment
land	uld be Aental rked o	To B	John William R	idenour			Grad	ce Jacks	on		
Mary	2 should I and Men Is marke aumatic		19a. Informant's Name/Relationsh	ip (Type. Print)	19b. Maili	ng Address (Street				or Town, State, Z	ip Code)
	and and and n 27		Helen K. Riden	our / wife		Maplewoo		. Hagerst	own, M	laryland	21740
aitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation	3 □Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	:e)	Date	20c. Lo	ocation - City or	Town, State
<u>=</u>	ment of tant: If ite		4 □ Donation 5 □ Other (Sp	ecify)	Smithebur	g Cremato	ory 🗀	1/22/2008	Smit	hsburg.	Marvland
a D	permit Depar Impor any ir		21. Signature of Funeral Service L	icensee	21	2. Name and Addres	ss of Facilit	^{ly} Rest Ha	ven Fu	neral Cl	napeĺ
ion	EB = 10 G		23a. Part1. Enter the disease, or o	complications that saves						town Mar	ryland 21742
	5-77		shock, or heart failure. List o	only one cause on each l	ine.	er the mode of dyin	ig, such as	cardiac or respirati	ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	s a consequence of):	cc				-	15 montes
	Examiner			Due to (or as	s a consequence of).	•					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as	s a consequence of):						
5	cuted nd ransit	Examine	that initiated events	с							
Š	e exe ian al urial-1		resulting in death) Last	Due to (or as	s a consequence of):						
0/00	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical		d							
o X	ding page as	യ	IF FEMALE:	23c. If yes, outcome	o of programov						
200	eath o	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)	,			23d. Date of deline Month	very Day Year
j.	the d y the iched	iysid	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	at time of death of				_		
7	w requires that the death certific been signed by the attending p should be detached for use as	by Pł	Part II. Other significant condition	s contributing to death t	but not resulting in the u	nderlying cause give	en in Part I.	. 23e.	Did tobacco u	use contribute to	the cause of death?
ecords	quire en sig uld bi	q pe							1 ☐ Yes 2	□ No 3 □ Pro	bably 4 ∐Unknown
ည က	aw re	Completed							Was an	24b. Were aut	opsy findings available
ב	The law te has b	L O						10 )	autopsy performed? 'es 2 No	death?	ompletion of cause of 2□ No
N Ea	ian; ertifica ctor, p	Be C	25. Was case referred to medical				26. Place	of Death (Check of		1 1 163	20140
5	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Outpatier	nt 3 DOA Othe	er: 4□Nu	rsing Home 5 🗗	Residence	6 □Other (Spec	ify)
<b>5</b>	ng P		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time o ay Year) Injury	f 28c. Injun Work	y at </td <td>28d. Desc</td> <td>ribe how inju</td> <td>ry occurred</td> <td></td>	28d. Desc	ribe how inju	ry occurred	
IVISION	tendi leath. tor: / the fu	cati	2 Accident investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation inves	ation			Yes 2□				
Š	or At after d Direc in by	Certification:	4 Homicide determin	led 28e. Place of in building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Locati City o	on (Street an r Town, State	nd Number or Ru e)	ral Route Number,
1	spital ours a neral filled		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, deat	h occurred at the tin	ne date an	id place, and due to	the cause/e	and manner as	etatod
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner si	of examination and/or in	vestigation, in my o	pinion, dea	th occurred at the	ime, date and	d place, and due	to the cause(s)
	To the Hospital or Attending Physician: The law requiviting 44 hours affect death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Me	29b. Signature and title of certifier	_		29c. License	e number	-	29d. Da	te signed (Month	, Day, Year)
)			Muchael	a nih	1 MA	0	7166	7		1.21.	08
	a 1-1		30. Name and address of person w	ho completed cause of	death (Item 23a) (Type,	Print)				1	ohun MO.
	911		Michael	- 40	ngele 11	110 N	edic	al Con	njuv	Mase	shun MO.
	Sta	te	31. Date filed (Month, Day, Year)	2003 32. Hegist	rar's Signature	and!				•	

I ype or Print in Black indelible ink. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygiene 2008	0   983
Cartificate of Dooth	

		-	1 - State Of Ivial yland / D	Certificate of			Reg. No.	01300
	Physicia	an	Decedent's Name (First, Middle, Last)			2. Date of Dea	oth 7 6 pay 2008 ear	3. Time of Death 6:30 a M
	/Medic	al	Walter Simms, Jr.  4a. Facility Name (If not institution, give street and number)	4b City Town o	r Location of Dea		4c. County of Dea	
	Examin	er	Charlotte Hall Nursing Home		tte Hall	ui	St. Mary	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birts	hday) If Under 1 Year	If Under 24 Hrs		h 9. Bir	hplace (State or Foreign ountry)
	Director		213-28-6993 /6	rs. Months Days	Hours Min	Feb. 10.		hian, Md.
	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location				10d. Inside City Limits
	Maryl f sho	ţō	Maryland St. Mary's Charl	lotte Hall				1X∑Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Co	puntry?
	th with	a D	89449 Charlotte Hall Rd.	20622			United St	
	be filed within 72 hours after death with the Maryland tral Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
0030	s afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 □ Yes 2 🔀 No	Specify:		Specify:	31ack
3	e hour	ted t	15 Decedant's Education 16a.	Decedent's Usual Occup	pation	- 1	16b. Kind of Business	/Industry
<u>ν</u>	within 72 ene. than "na he Medlc	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT use retire 'ransportati	during most of wi d) on Drive	orking	Private	
7	filed wit Hygiene other the	S	10	Tansportati				
and	be filed tal Hygid d other event, tt	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Parker	Maiden Surname)	
Z	should by and Ments marked umatic ev	욘	Walter Simms, Sr.  19a Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street			er City or Town State	Zin Code)
Z Z	2 sa ls		(1)	12 Cabot St				20747
و ف	s 1 and f Health item 27 other t	- 3	20a. Method of Disposition 20b. Place of	Disposition (Name of ry, crematory or other pla	rect DIC	Date	20c. Location - City or	
E E	Pages nent of nrt: If Its iry or o		1 Burial 2   Cremation 3   Hemoval from State	nd Veterans	1 .	6/2008	Cheltenham	. Md.
Бапт	# 돌 <b>달</b> # .		21. Signature of Funeral Service Lic. 4 ee	22. Name and Addre	ess of Facility On	De. /P.A.	tville, Md	207/7
ñ	permi Depar Impor any Ir		TOUR a Days MOLES	5538 Mar	Iboro P	ké/Fores	tville, Ma	. 20747
			23a. Part 1. Enter the disease, or complication, that caused the death. Don shock, or heart failure. List only one cause on each line.	not enter the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician	Ĥ	Immediate Cause (Final disease or condition a.	ension				Oriset and Death
	/Medical Examiner		resulting in death)  Due to (or as a coust quence of	of):	#.1	0:		
	EXAMINET.	<u>_</u>	Sequentially list conditions, b.	C CON W	WILL II	M Our	eerc	
	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	hat	2 Day			
Ť.	execu in and ial-tra	Exa	resulting in death) Last  Due to (or as a consequence of	of):				
09/89	eath certificate be executed attending physician and for use as the burial-transit	edical	d. Com	and di	(con			
			IF FEMALE:					-
X Q Q	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?		;у		23d. Date of de Month	livery Day Year
- :	The law requires that the death cer tte has been signed by the attendir bage 2 should be detached for use	Physician/N	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify)				
7.	w requires that the d been signed by the should be detached	/Ph	Part II. Other significant conditions, contributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
<b>Records</b> ,	quires n sign ald be	d by	Cout, of			10	Yes 2√√2 No 3 🗆 F	robably 4 □Unknown
ပ္ပ	aw red s bee	Completed	Signel Mach			24a. Was	an 24b. Were a	utopsy findings available completion of cause of
	sician: The law certificate has l irector, page 2 s	lmo;	12/ Paul Die	nel blace		perfo	rmed? death?	
Vital	slan: ertifica ctor, I	Be C	25. Was case referred to me ical examiner?			eath (Check only o		
or >	Physician: this certific ral director,	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Ot	her: 4 Nursing	Home 5 ☐ Resi	dence 6 □Other (Sp	ecify)
	ding P. h. After i	ion:	Natural 5 ☐ Pending (Month, Day Year)	Fime of 28c. Injury Wo	ıryat ork? ]Yes 2∐No	28d. Describe	how injury occurred	
DIVISION	tten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, fa			28f. Location (a	Street and Number or F	Rural Route Number,
<u>≥</u>	after after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)			City or To	wn, State)	
	e Hospital or A 124 hours after c e Funeral Direc letely filled in by		29a. Certifier (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (C	e, death occurred at the t	time, date and pla	ce, and due to the	cause(s) and manner a	is stated.
	To the Hosp within 24 ho To the Fune completely f	Medical	one) and manner stated.		se number			
	To To	2	29b. Signature and title of dertifier				29d. Date signed (Mor	
2	(		30. Name and address of person who completed cause of death (Item 23a)	(Type Print)	0575			7,2008
_	(3)		Ahmed Heshmat, M.D. 29449 Ch	arlotte Hal	1 Rd. Ch	arlotte	Hall, Md. 2	20622
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
	Regist	rar	JAN 1 1 2008 King at 15 Comme					

			1 - For State Registrar	State	of Marylar		artment of H				giene Reg. No.	2008		981
\$	Physici		Decedent's Name (First, Midd     Margaret All	,	lattery					2. Date of De Month January	eath Day	Year	3. Time o	5 M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	or Location	of Death	January	<u> </u>	County of Death	12:15	
apr	Funeral	4.	Arcola Health & R 5. Social Security Number	ehab. Cente	7. Age (In yrs.	last birthday)	Silver Spr If Under 1 Year	_	24 Hrs.	8 Date of Bir		Montgomer	y place <i>(State)</i>	or Foreign
	Director		579-20-9971	1 □ M 2 <b>K</b> F	84	Vm	Months Days	Hours	Min.	8. Date of Bir (Month, Da July 2		Cou	ntry) t Viro	
	w		Usual Residence of Decedent  10a. State 10b, County	,	10c Gi	ty, Town or Lo	cation						10d. Inside C	
	Maryli f sho led at	tor		tgomery										aty Limits 2 <b>∑</b> No
	th the or 28a	Director	10e. Street and Number	cgomery		ilver	10f. Zip Code				10g. Citiz	en of What Cou	ntry?	
	ath wi	ral	901 Arcola Av					0902				USA		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If term 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	ried Armed F	a 2 <b>∃x</b> No Give	i i	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ ★ ₩o	lispanic Or an, Mexica Specify:		ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, SpeciWhite	etc.	
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7	led wit lygiene ner the rt, the	Соп		5+		11	Docket Of					ral Gov	ernmen	ıt
alla	d be fill antal H ed oth	Be	17. Father's Name (First, Middle, Forrest Allen	,						(First, Middle,		Surname)		
Ž	2 should I and Men Is marke	욘	19a. Informant's Name/Relations			19b. Mailin	ig Address (Street			McKeni		Town State Zir	Cada)	
Mic.	and 2 : ealth a n 27 Is ier trau		Margaret Papov		nter		4 DeSale							
บ์ บั	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Bemoval from		Place of Dispo	sition (Name of natory or other place	ce)		Date	20c. Loc	ation - City or To	own, State	
altillo	t. Pages rment of I rant: If ite		4 □ Donation 5 □ Other (5	Specify)	Me		itan Crem	, -	20	80	Ale	xandria	, Vira	inia
ם ח	permit. Departr Importa any inju	,	21. Signature in Funeral Service	Licensee	00		Name and Addre							
8	A		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that	caused the deat	h. Do not ente	Univers  or the mode of dyir	ng, such as	cardiac c	w., Si	llver rrest,	Spring	, MD 2 Approximat Interval Bet	
	Physician	F 9	Immediate Cause (Final disease or condition	-	heimer':								Onset and	ween Death ars
	/Medical Examiner		resulting in death)	Ci.	o (or as a conseq									ars
	9 <u>%</u> 2	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a conseq	uence of):								
	cuted nd ransit	Examiner	that initiated events	G.										
Ś	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	o (or as a conseq	uence of):								
2	icate t physic s the b	dical		d		-								
5	death certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome pf pregna						23	3d. Date of delive	erv	
ה ה	Attending Physician: The law requires that the death certificate be executed refeath.  ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 ☐ Feta gnant at time of d nown		Ectopic pregnancy Other (specify)					Month		Year
	that the		Part II. Other significant condition	ons contributing to a	death but not res	ulting in the un	derlying cause give	en in Part I,		23e. Did to	obacco use	e contribute to the	ne cause of d	leath?
2	w requires that the diperent signed by the should be detached	ed by	Cerebrovascula	ar Accide	nt					1 🗆 Y	/es 2 <b>K</b>	No 3□ Prob	ably 4 □l	Jnknown
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3	sician: The la certificate ha irector, page 2	S								perfo	rmed?	death?	2 No	ause or
	sician certifi rector	Be	25. Was case referred to medica examiner?	Hospital:			3 DOA Othe	251		(Check only of				
5	g Phys er this eral dii	<u>ا</u> ي	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of	28c. Injun	4X_I NU		ne 5 Resid		Other (Specification)	y)	
5	endin sath. or: Aft he fun	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	nth, Day Year)	Injury		<br Yes 2 ☐ !	No					
	al or Att	Certification:	3 ☐ Sufcide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place build	e of injury - At ho ling, etc. (Specif	ome, farm, stre	eet, factory, office		2	8f. Location (S City or Tow	Street and i	Number or Rura	I Route Num	ber,
		Medical C	29a. Certifier (Check only one)  1 ☑ Certifyin 2 ☐ Medical	ng Physician: To the Examiner: On the b and	e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ded at the time,	cause(s) a date and p	ind manner as st place, and due to	tated. the cause(s	:)
1	Within To the COMP.	ž	29b. Signature and title of certified		0		29c. License	number		2	29d. Date	signed (Month,	Day, Year)	
/	10		1 Arai	1 Cox	rely		De	09834			Ja	anuary 9	, 2008	3
			30. Name and address of person Barry Rosenbaum		•		rint) venue, Ke	ancin	aton	MD 20	QQE			
	Stat	е	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ture		TILGIII	y con	, FID 20				
	Registra	ır	JAN 11	2008		1. Ann	colo B							İ

		For State	State of Maryla	and / Depa		Health and Mo	ental Hygi	ene 00	e. 3 01985
Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Las  LOUS Hamus  4a. Fecility Name (If not institution, give	SAGO	· 2 a			2. Date of Death Month	Day Ye	
Funeral Director		402-16-4533	7. Age (In y	rs. last birthday)	STEVEN If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	QUEEN  Year)  , 1921	ANNE'S Birthplace (State or Foreign Country) TEXAS
with the Maryland a or 28a-f show be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND QUEEN A  10b. Street and Number	ANNE'S	City, Town or Lo	VILLE 10f. Zip Code			g. Citizen of Wha	
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. do other than "natural", or items 23s or 28s-1 show event, the Medical Exeminer man be notified at	d by Funeral	244 MATTAPEX PLAN  11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 1 No	lispanic Origin? (Specian, Mexican, Puerto P Specify:	cify Yes or No- lican, etc.)	Black, \ Specify:	American Indian, White, etc. WHITE
D D .	Be Completed	15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire STAL WORK	during most of workin d)	g	POSTAL  [aiden Sumame]	,
nd 2 should lth and Mer 27 is marka r traumatic	To E	MARION MONROE MCA  19a. Informant's Name/Relationship (T.  DONNA H. PEREIRA/  20a. Method of Disposition	ype, Print)  DAUGHTER	244 1	MATTAPEX sition (Name of	De	Route Number, LANE,	City or Town, Sta	ILLE, MD 2166
permit. Pages 1 ar Department of Hea Important: If itam any injury or other		1	Removal from State	cometery, crei ST EMORY GA 22 FF	natory or other place ONEWALL ARDENS 2. Name and Addre	JANUAI 200 pss of Facility	RY 15 8 M AND NEW	ANASSAS,	VIRGINIA RAL HOME, P.A
Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	ic ations that caused the do not cause on each line.  a  Due to (or as a cons	path. Do not ent					Approximate Interval Between Onset and Death
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that the death certificate ed by the attending phy detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1□Live birth 2□Fi 4□Pregnant at time o 9□Unknown	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	delivery Day Year
requires the been signer should be d	eted by	Part II. Other significant conditions co	ntributing to death but not r	-	nderlying cause giv	en in Part I.		2 □ No 🕰	Probably 4 Unknown
The lar ate has page 2	Be Compl	25. Was case referred to medical examiner?				26. Place of Death	autopsy performe 1 Yes 2	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\subseteq\) No
ding Phys	2	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 □ Inpatient 2 28a. Date of Injury (Month, Day Year)	□ ER/Outpatien 28b. Time of Injury	28c. Injur Wor	vat 28	e 5 Mesiden 3d. Describe how		Specify)
To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	cal Certification:	3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exami	28e. Place of Injury - At building, etc. (Spe	nowledge, death	occurred at the tin	ne, date and place, ar	City or Town,	State)	r Rural Route Number,
To the Howithin 24 To the Fu	Medical	29b. Signature and title of certifier	ner: On the basis of exami and manner stated.	mation and/or inv	29c. Licens		290	d. Date signed (M	
Star Registra		30. Name and address of person who co ANTHONY M. CAPUTO. 31. Date filed (Month, Day, Year)	M.D. 139 32. Registrar's Sig	OLD SOL	OMONS ISI			,	YLAND 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year tatricia 20 /Medical January 8006 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Hapkins Itimore, Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 58 234-80-2762 May 30, 1949 МD a or 28a-f show the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Director Cumberland 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a "natural", or items 23a 619 Lynn Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo þ Specify: 3 Widowed 4 Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed war and Mental Hygie <u>homemaker</u> <u>own home</u> permit. Pages 1 and 2 should be filec Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Houdershell Edith M. Houdershell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Siefers husband 619 Lynn Street Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 1/25/2008 MD 4 ☐ Donation 5 ☐ Other (Specify) LaVale 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) **Physician** /Medical ue to ( a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has certificate death? 1 ☐ Yes 1□ Yes 2□ No 2 To the Hospital or Attending Physician: this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient ၉ 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

S

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

January

Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

hours after death 24 hours a within 2.

Medical State Registrar

title of certifier 29b. Signature a

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D51520

January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bahram Pishdad, M.D.; 1328 Southern Avenue, S.E.; Suite 310; Washington, D.C. 20032

31. Date filed (Month, Day, Ye

29a. Certifier

(Check only one)

and manner stated.

State of Maryland / Department of Health and Mental Hygiene

01988

Physician	
/Medical	
Examiner	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phy /M Exa

Division or Vital Records, P.O. Box 68760,

an 🕆	Decedent's Name (First, Middle, La  Page 1.4	,	on C-			2. Date of Dea Month	th Day	,	Year	3. Time of Dea		
cal		Andre Thornt	on, Sr.			January		200		1:20 A.		
ner	4a. Facility Name (If not institution, gi		***		r Location of Death			County o		007700		
iy ac-	Prince Georges  5. Social Security Number 6.		rer yrs. last birthda		everly If Under 24 Hrs.	8. Date of Birth				eorges		
		1 <b>X</b> M 2□ F 49		Months Days	Hours Min.	8. Date of Birth (Month, Day December		958 6,	Count Wash:	lace (State or For try) ington, D		
	Usual Residence of Decedent	100	. City, Town or	Location								
_	10a. State 10b. County									0d. Inside City Lii 1 <b>X</b> Yes 2 ☐		
ecto	Maryland Prince Georges Capitol Heights											
l Dir	10e. Street and Number 10f. Zip Code 20743							10g. Citizen of What Country?  United States				
ner	11. Marital Status	12. Was Decedent Ever i	in U.S. 13	3. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Sp	ecify Yes or No-	1		- America			
by Funeral Director	1 □ Never Married 2 □ Married 3 □ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No		Hican, etc.)			, White, 6	_		
Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. Dec	cedent's Usual Occup ve kind of work done	oation during most of work	ina I	16b. Kir	nd of Bus	iness/Ind	lustry		
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S	12th grade		Aut	o Car Sal						otors		
Be	17. Father's Name (First, Middle, Las				18. Mother's Name	(First, Middle,	Maiden	Surname	)			
ု	George Francis	s Thornton			Gladys	Theres	sa (	Gate	S			
	19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	uiling Address (Street	and Number or Run	al Route Numbe	r, City or	r Town, S	State, Zip	Code)		
	Ronald Andre Thou	rnton,Jr. (So	n) 791	3 Mandan	Road:Apt.	Γ-2:Gree	enbe	lt.M	arv1	and 2077		
	20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 [	□ Removal from State	b. Place of Dis cemetery, ci	position (Name of rematory or other pla	ce) Jan. l	Date .4,2008	20c. Lo	cation - C	City or To	wn, State		
	4 □ Donation 5 □ Other (Spec	/	Chesap	eake Crema						Marylan		
	21. Signature on Funeral Service Crossee  22. Name and Address of Facility  R. N. Horton Company Morticians, Inc.  600 Kennedy Street, N.W.; Washington, D.C. 20011											
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	shock, or heart failure. List only	23a. Part1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
4 1	disease or condition resulting in death)  Cardiac Arrythmia minutes											
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Į.	resulting in death)	Due to (or as a con	sequence of):  ry Fail							_		
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edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, and the part is a cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a con  Respirato  Due to (or as a con  Due to (or as a con  C. None Ische  Due to (or as a con  Lemphysema  23c. If yes, outcome pf pre 1   Live birth 2   Fed   4   Pregnant at time 9   Unknown  Contributing to death but not  Aneurysm Diss  Venous Thromb  Cocci Sepsis  Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Yea.  Completed cause of death (	resulting in the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the sect	rdiomyopat  B   Ectopic pregnance   Other (specify)     underlying cause give  ient 3   DOA   Other (specify)     underlying cause give   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give   ient 3   DOA   Other (specify)     underlying cause give give give give give give give giv	26. 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W product   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See contril   1   See	of delive th bute to the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state	inutes  days  days  Pry Year  Day Year  Day Year  Day Ax Unkr  Day House Number,  Day, Year)		

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours a

Certification: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32800 1/22/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert Washington 32 Registrar's 11701 Livingston Rd. #205, Ft. Washington, Md. 31. Date filed (Month, Day, Year) State **ORIGINAL** 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Fortate Registrar Amend #788 perInf, 0875, 1/28/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** :55 A M JOIO 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 9. Date of Birth (Month, Day, Year) 1910 9. Birthplace (State or Foreign Month, Day, Year) 1910 North Cambridge 4c. County of Death Examiner Strict Heights 2125 Harwood Roac 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days 1 □ M 2 🗙 F Hours 133-14-9806 97 102 Director North Carolina Usual Residence of Decedent the Maryland r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Funeral Director Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or ber 2074 USA ns 23a (must h Harwood 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 7 is marked other than "natural", or Items traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify Specify: Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) D.C. Public Schools Musician leacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h Be amin Dughter 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 20147 19a. Informant's Name/Relationship (Type. Print) District Heights HI 12125 Harwood Rd if of Health a Ellen WashingtoniHle Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 No Removal from State Department of Important: If any injury or once, edar Hill 1/11/08 Washington NC 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Home 20147 5538 Forestville Hd Mariboro Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eare 00 disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner ROUT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed 2 burial-tra Due to (or a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes **X**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: / 2 Accident investigation death. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital e within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) YXX 46046 MD tram 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAPLATA, MD ALIKHANI centennial 50 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 FLT NATHANIEL WILLIAMS January 7:33A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 20 9. Birthplace (State or Foreign Country) South Carolina 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 → M 2 □ F 1943 248-70-8099 64 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Director Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 601 E. Randolph Rd., Apt.111 USA filed within 72 hours after death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 21 No Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene, is marked other than Driver Taxi Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Sam Murray Williams Loretta ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Louise P. Williams, Wife 601 E. Randolph Rd., Apt.111, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 01/14/2008 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jordan Funeral Service, 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part1. Enter the disease, corpreshock, or heart failure. L. st. rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** CORONARY ARTERY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE equantially list so utilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine END STAGE RENAL DISEASE - DIALYSIS DEPENDANT certificate be executed Due to (or as a consequence of): Box 68760, DIABETES MELLITUS Physician/Medical as attending properties as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. the 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has page 2 autonsy performed' certificate 1□ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 👿 No 1 Inpatient 2 X ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔯 Natural 5 ☐ Pending investigation within 24 hours after common to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 51670 January 2008 angon rou 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towana L. Spriggs, MD 8405 Ramsey Ave., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 4 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 🔎 🕦 🥱 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CART. BERNARD WRIGHT JANUARY 8 2008 2:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F 293-40-4261 Yrs. Director 60 JUNE_15 CLEVELAND OHIO _1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD PRINCE GEORGE'S 1 Y Yes 2 □ No Director LARGO 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 658 MOUNT LUBENTIA COURT 20774 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XI Yes 2 □ No ARMY If Yes, Give Year or Dates; 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify þ BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 12th DATA PROCESSOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK WRIGHT, JR. ٩ MATTIE HOWARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD WRIGHT/BROTHER 658 MT LUBENTIA COURT LARGO, MARYLAND 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) MD VETERANS CEMETERY: 1/14/2008 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditior resulting in death) A1205 /Medical Due to (or as a consequence of): Examiner Inflications Juster Drift rtk Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has be irector, page 2 s autopsy performed' 1∐ Yes 20 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 XInpatient within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred Driver 27. Manner of Death 28a. Date of Injury 28h. Time of Certification: 28c. Injury at Work? control 1 Natural 5 Pending investigation 23 1 Yes 2 JAR 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) for a way of the control of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) for a way of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause lace of injury. At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) - R Broo D004918 5 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN R. BROOKS M.D. 8909 OLD BRANCH AVENUE CLINTON, MARYLAND 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 1 4 2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Vear **Physician** Mulindwa Wamala 7,2008 8:50 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Cross Hospital Holy If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**∑**M 2□F 40 578-21-6988 Yrs. <u>June 11,1967 Uganda</u> Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Laurel Md. Prince Georges Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5802 Holger Court 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 X Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2K No Specify: þ 3 Widowed 4 Divorced "naturei", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Car Dealership permit. Peges 1 and 2 should be filed with Department of Health and Mental Hygien important: If item 27 is marked other the eny injury or other traumatic event, Ins., page. Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kizza Kanonya Mary Wamala Sirie м. В. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5802 Holger Court, Laurel, Md. 20707 Faridah Sendagire- wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/13/08 Entebbe, Uganda Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signat re i Funeral Son ice Licens e 411 Kennedy St., N.W. Wash. DC 20011 Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks **Physician** Cereberal Edema /Medical Due to (or as a consequence of): Examiner weeks Toxoplasmosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine days the burial-transit or Attending Physicien: The law requires that the death certificate be executed Pneumonia and Due to (or as a consequence of): Box 68760. physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 III Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 Yes 2 No 1 Yes : Aftar this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 X Inpatient 2 ER/Outpatient 3□ DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after de. 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide To the Hospitel of within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Gailhersburg PO BOX 83819 NAWAZ MO. 32. gegistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

			1 - For State Registrar	State of Marylan		artment of I		and Me		ene	38	019	194	
	<u> </u>	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month			3. Time of	Death	
		Physician   Donnie Josie Vean Wright							1	Day 1 2	08	1:00	P M	
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			1106 Petersvill			Bruns				Free				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day,	Year)	(ear) 9. Birthplace (State of Country)			
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	land		10a. State 10b. County	10c. City	, Town or Lo	cation						10d. Inside Ci	ty Limits	
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	r 28e	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of V	Vhat Cou	intry?		
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	dea	Funerai	11. Marital Status	. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of 1 Yes, specify Cut	Hispanic Original	gin? (Spec	rify Yes or No-		e - Ameri k, White	ican Indian,		
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	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
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Registrar

31. Date filed (Month, Day, Year)

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32. Registra's Signature

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Attend death ctor; y the f	ficati	ZELACOREN							□ Yes 2 □ No e 28f. Location (Street and Number or Rural Route Num					ral Route Number.		
tal or / s after al Dire	Certification:	3 Suicide 4 Homicide  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)														
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								29d. Date signed (Month, Day, Year)					2			
		20 Name ======	ross of parent	M 7	an to	2, ^	ON (Turn	Print)	079	-/	yer	ma	mary 18, 2008			
541		30. Name and addr	ICA A	Santos	M.	D. VA	Mari	Hand H	ealth	Care Sys	tem	Por	ry Pa	sint mary	iand	
Sta Registr		31. Date filed (Mon	ith, Day, Year)	2008	2 Registra	ar's Signatur		84E)	•	Care Sys		1		- (		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2008 1:01 PM **JAMES** CHRISTOPHER WAHL SR January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 5, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1**XX**M 2□ 214-80-9675 45 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5813 Bell's Lane 21704 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2CXNo Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fitter/Installation Gas Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Ralph Wahl Edna Exa Culler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Christopher Wahl, Jr, Son 7996 Windsail Court, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Smithsburg Crematory Jan 21, 2008 Smithsburg, Maryland 4 ☐ Donation 5 Other (Specify 21. Signature Andal Service Licen 22 Keeney & Bastord P.A. Funeral Home #100706| 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) AnoxIL brain Due to (or as a consequence of): actension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Disease folmonery Obstructive Chronic Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

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Department of I Important: If its any injury or of once.

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

/Medical

Examine by Physician/Medical attending phase as t Be Completed Certification: To n 24 hours aft le Funeral Di letely filled in Medical within 24 ho

To the Function

completely

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify)	Month Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown			
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No			
25. Was case referred to medical	26. Place of Death (6	Check only one)			
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? on M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not determine		f. Location (Street and Number or Rural Route Number, City or Town, State)			
	hysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				

29c. License number

D0064624

29d. Date signed (Month, Day, Year)

2008

State

Registrar

Sandeep Sharma, M.D., 31. Date filed (Month, Day, Year)

JAN 25

29b. Signature and title of certifier

400 West Seventh Street, Frederick, Maryland 21701 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:06 January 6, 2008 4c. County of Death /Medical Roger Yee Doo 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11419 Monterrey Drive Wheaton Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 **3** M 2 □ F Yrs. 292-16-2952 Director 91 May 29, 1916 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be marked at a light or other traumatic event, the Medical Examiner must be marked at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Wheaton 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 11419 Monterrey Drive 20902 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Asian Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Restaurant Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be See Tom Ket Quon Yee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 Red Tail Court, Silver Spring, MD 20905 Donald Yee/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11, Jan. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or co-polic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

500 University RIvd, W. Silver Spring, MD 20901.

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non-Small Call Lung Cancer vears /Medical Due to (or as a consequence of) **Examiner** Done Metastasis
Due to for as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 Months Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown has been signed by je 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Renal Failure, Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 😾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760 e Funeral Direct within 2

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN

Linda Burrell, MD

11

2730 University Blvd, West, #400, Wheaton, MD 20902 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

d35996

29d. Date signed (Month, Day, Year)

January 10, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SHUN NAN ZHENG JANUARY 2008 11:14 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 N F 579-29-5683 70 Director September 12, 1936 Korea Usual Residence of Decedent 10c. City, Town or Location 10h. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No Frederick **Ijamsville** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9546 Doctor Perry Road 21754 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Asian Chinese 1 ☐ Yes 2 🛛 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home + 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Unknown Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Insu Kim / Husband 9546 Doctor Perry Road, Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State January Smithsburg, Maryland Smithsburg Crematory 4 □ Donation 5 □ Other (Specify) 22, 2008 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church Street, Frederick, 21. Signature of Funeral Service Licer M01433 MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OMA disease or condition resulting in death) /Medical Due to (or as a consequence of): myocardial mfarction Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural

burial-transf ng physician a as the burial-P.O. Box 68760, attending use signed by the a d be detached f Division or Vital Records, certificate has

this

After t

To the Hospital or Attending

hours after death.

24 hours after death e Funeral Director:

within 2

Baltimore, Maryland 21215-0036

28c. Injury at Work?

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

6 Could not be determined

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year) 00035106 1/20/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, Maryland 21701 Myung Hee Nam M.D.

State Registrar

Medical